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This guide developed for use in the secondary schools of New Jersey makes suggestions for venereal disease education which have been tested in a wide variety of classroom situations. The document focuses on the kinds of questions for which young people are seeking answers. An attempt is made to illustrate problems which might become a framework for study. Many suggestions are made for motivating students and teaching the topic. Appendixed is teacher background information which includes article reprints, research data, a film list, and a wide variety of references. (DS)

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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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a teaching reference guide

VENEREAL DISEASE

SE 006 545

DIVISION OF CURRICULUM AND INSTRUCTION
DEPARTMENT OF EDUCATION
STATE OF NEW JERSEY
in cooperation with
NEW JERSEY STATE DEPARTMENT OF HEALTH

Venereal Disease

A TEACHING REFERENCE GUIDE

Compiled by Phyllis S. Busch, Consultant

Division of Curriculum and Instruction
Department of Education
State of New Jersey
in cooperation with the
New Jersey State of Department of Health

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STATE OF NEW JERSEY
DEPARTMENT OF EDUCATION
225 WEST STATE STREET
TRENTON, N. J.

OFFICE OF THE COMMISSIONER

To The Schools of New Jersey:

The rising incidence of venereal disease, particularly infectious syphilis, among teenagers has become a matter of concern to the Department of Health and the Department of Education.

The Department of Education has attempted to prepare, in cooperation with a number of outstanding teachers, an educational unit which will inform young people in the secondary schools of the causes and serious consequences of venereal infection. We recognize that this is only one approach to the problem but we do believe that substituting knowledge for ignorance may be the first step in prevention.

The experimental work done so far has the endorsement of this Department and it is our hope that it may be continued and extended to the secondary schools of the State.

Sincerely yours,

Commissioner of Education

FOREWORD

In our efforts to plan educational programs that deal with problems of youth and which have major social implications, we are pleased to make this document available to the schools of New Jersey. Statistical records of recent years give specific evidence of the extent of the problem of venereal disease among young people in the State and in the Nation.

The problem of venereal disease among our youth is one of the most serious issues of our time. The vicious tentacles of the problem have begun to engulf the young people now in our schools. We dare not ignore the alarming increase in venereal disease among school age children. The complexity of this problem and the many subtleties related to it make it an increasingly difficult area. It is my genuine feeling that wherever concerns exist in the minds of young people schools have a responsibility to meet these concerns directly and effectively.

As early as 1962, the New Jersey Department of Health urged that a joint effort by the departments of Health and Education be directed toward an extensive educational program to inform our youth and their parents of the seriousness of New Jersey's Venereal Disease problem.

The materials which have emerged and which are presented in this booklet make it possible for the school to increase its efforts on the venereal disease problem with confidence and with accurate information. The suggestions presented in this publication have been carefully screened and tested in a variety of classroom situations by a pilot group of New Jersey classroom teachers from all areas of the State.

This document attempts to develop the premise that the soundest approach to venereal disease education is one which starts with the questions of young people themselves. An attempt is made to illustrate problems which might become a framework for the study. Many suggestions are given for motivating students and for teaching the topic. It is not felt that a teacher should attempt to teach all of the material in this document, rather it is felt that the teacher might well use it as illustrative of kinds of things she can do. It is suggested that the teacher might well become fortified with the background information and use it as a basis for planning more directly with her class or with individual students.

The intent of this document is to stimulate inquiry, discussion, and problem solving among New Jersey youth to the end that our students will be more knowledgeable and will develop positive values dealing with this important area of human life.

The reaction to the topic of venereal disease as an important area of curriculum has been one of strong endorsement and encouragement by administrators, teachers, parents and children.

It is our hope that this effort, in some small way, will contribute to the eventual eradication of venereal disease.

Robert S. Fleming
Assistant Commissioner of Education
New Jersey State Department of Education

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Special gratitude is due those teachers from all parts of the state who participated actively in the testing of the source book and in evaluating it critically. They gave generously of their time and efforts to learn the subject matter and the most effective way to present it, to teach a unit on V.D. and finally to evaluate the source book. The present form of the book is the result of their contributions. The teachers who cooperated are:

ATLANTIC COUNTY
Atlantic City High School
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Oakcrest High School
Mr. George Butrus

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PART I

BEFORE YOU TEACH ABOUT VD, CONSIDER TODAY'S YOUTH

You can do an effective teaching job only if you understand the concerns of those who are being taught. Young people today are different from those of a generation ago. They live in a changed and changing world. The different values of the twentieth century are having a profound influence upon the developing adolescent. We know that as the young person matures he has a need to become independent, feel accepted, find security, attain personal achievement, etc.

However, this growing up is taking place in a society characterized by greater permissiveness, increased materialism and the pursuit of pleasure. Concurrently there has been a lessening of the influences of institutions such as family and school. As a result the behavior of youth today reflects a greater moral laxity and a pattern of teenage rebellion.

Among the consequences is the high incidence of illegitimate births among teenagers and the current sharp increase of infectious venereal disease among young people. Although teenagers comprise 13% of our population over 50% of reported infectious VD cases are teenagers. Studies have indicated that homosexuality is a contributing factor to the increase of venereal disease among young people.

Replacing ignorance with knowledge is an important factor in eradicating VD. We, as educators, have an important job to perform. Education in school together with proper cooperation at home and by the community should help make VD as intolerable as smallpox or the plague and succeed in bringing about its eradication. Because of the nature of the topic and because there is such a lack of general knowledge and guidance in this area it behooves the teacher to lead the way by providing correct information and by helping to develop intelligent attitudes concerning VD. The teacher can best accomplish these ends by familiarizing himself with the concerns of his pupils and by remaining sensitive to their problems and questions throughout his teaching.

VD is a serious problem

Venereal disease today is one of the basic problems of youth. With the advent of penicillin it was thought that venereal diseases (syphilis and gonorrhea) were on their way to being eradicated. There was a downward trend in the number of cases after 1948 and this decline continued until 1957. Since then VD cases began to increase. In 1960 and 1961 there was a 50% increase in primary and secondary syphilis and the numbers still continue to rise. In 1962 over 20,000 cases of infectious syphilis and over 250,000 gonorrhea cases were reported. This was the highest number in the ten preceding years. Actually it has been estimated by experts that the reported number is three and one-half times less than the actual number.

Early syphilis is extremely infectious. The symptoms disappear after a while even without treatment. However, if left untreated, the germs get busy destroying various parts of the body. Twenty years or more later one in fifty persons will go insane, one in fifteen will suffer death from a heart attack, one in two hundred will become blind. It all depends upon which organ the disease germs invaded. Some 4000 persons die from syphilis each year and as many babies are born with this disease which they contracted from their infected mothers. All this can be prevented.

Whom shall we teach about venereal disease?

Simply, the answer is: all who are concerned. From information received from the U. S. Public Health Service the increase in syphilis among the 15-19 year olds has tripled from 1956 to 1962 as well as among those under 15. It has almost quadrupled in the 20-24 year age group. We have to begin where these figures indicate that trouble begins, somewhere in the fifth year of elementary school according to the evidence.

Where should we teach about venereal disease?

Surely, as part of the study of health and within the context of the study of the body, knowledge concerning the human reproductive system merits at least the attention given the circulatory system or the digestive organs. In the sixth year syphilis and gonorrhea could be included within the framework of communicable diseases. In health, general science, or biology, depending upon the school, the subject of VD could be treated adequately and logically.

It is important that in each school a plan of articulation should be developed between the grades so that information grows with the child and his needs, building upon his previous learning, and not taking him through endless circles of repetition.

How should we teach about venereal disease?

The teacher should first inform himself concerning the facts of VD and thus develop his own self-confidence in teaching in this area. This will reflect in his teaching and affect the students' attitudes. Proper attitude is crucial to success in this area.

Then, taking the children where they are, the teacher must acquaint himself with the needs and backgrounds of his students. An atmosphere for questioning should be encouraged. These questions will reveal the concerns of the pupils. The teacher should listen to what is being said and asked in order to find clues to the problems of young people. Some questions might be answered directly. Other questions need not be answered as soon as they are verbalized. Rather they become the avenues for procedure leading to further inquiry wherever possible.

With these goals in mind this sourcebook on VD has been developed. It is hoped that with the material presented here each teacher can find sufficient information to familiarize himself with the important aspects about VD and to plan stimulating lessons for his students.

Throughout the reference guide, suggestions are made for using pupils' questions in group activities where each member of the class has an opportunity to recognize that he may be seeking a solution to the same problem. (See Problem IV and Motivating techniques 1, 2 and 3.)

Certain questions which, for various reasons, cannot be resolved in the classroom, can be handled in other ways. Private discussions or appropriate referrals can be utilized at the teachers' discretion.

What are the Goals in Teaching about VD?

The goal is to eradicate VD from among our youth and ultimately, from the world. It is hoped that this purpose can be accomplished by effective teaching about the nature of VD, how it is spread, how it can be cured, and above all, how it can be prevented. At no time is it expected that teachers give advice concerning products or practices which should be handled by a physician. This includes medication or other materials sold commercially and purported to prevent or cure venereal diseases.

By remaining sensitive to the concerns of youth, throughout the unit the teacher can help to affect the attitudes and behavior of students so as to make VD intolerable.

PART II

HOW TO USE THE SOURCEBOOK

The Plan of the Sourcebook

The need for teaching about venereal disease, together with some guidelines for approaching this area are developed in the section "Before You Teach About VD." The plan of the sourcebook is then presented so that the teacher will be informed of the available resources at his disposal.

"How to Use the Sourcebook" is an explanation of how to make the most efficacious use of the book as it was designed. This is followed by "Some Motivating Techniques" offering several means for launching the topic.

The "heart" of the sourcebook follows. Several problems are introduced. What is venereal disease, why should we be concerned about VD, how does one get it, what should one do about, how do we control it? These problems, together with a variety of procedures for helping the students discover the answers, are presented. The final understandings which should be developed as a result of investigating each problem are also given.

The problems should center about the questions of youth. Based on these questions, the teacher selects those problems or parts of problems which are related to the pupils' concerns. The teacher may find it desirable to change the order of the problems, to expand some, omit others, or add new ones. As children vary so do their problems. Accordingly, the teaching must also vary. This reference guide invites such needed flexibility.

A section on evaluation has been included as a guide only. It indicates a variety of ways in which the teacher can determine how effectively he has achieved his goals. It is important to bear in mind that evaluation is a two-sided affair. It serves to test the teacher as it tests the student. Note the emphasis on changing attitudes concerning venereal disease. The teacher should develop a number of different kinds of testing techniques designed to find out whether the aims of this unit have been achieved. All aims should focus on ultimate eradication of venereal disease. In order to do this certain knowledge has to be gained, attitudes may have to be altered, and, in some cases, certain action may have to be taken.

The Appendix has been designed to help the teacher plan his lessons by giving him some content information, selected reprints of articles on VD, an up-to-date bibliography, an annotated list of films, a glossary of terms, and other useful supplementary materials.

Because information on VD is increasing rapidly at present, it is important to keep this information up-to-date. In order to do an effective teaching job in this area the teacher must not fall behind current knowledge. The blank pages following each problem are provided to enable the teacher to add new material pertinent to that problem as it appears.

Suggestions for Using the Sourcebook

1. Decide on the amount of time you wish to allot to the topic of venereal diseases.

2. Select from the list of motivating techniques the one or ones most suitable to your class according to age, background, interest, needs. Initiate a stimulating motivation for the unit.

3. Note the section, "Problems", following "Some Motivating Techniques." Again considering the needs of your class decide whether you want to introduce all four problems or fewer. For example Problems II and III can be treated together. Perhaps another order than the one presented here appears more logical. Following this decision read over all the items under "Suggested Methods of Procedure" which have been developed. Select one or more which you think can be adequately handled by your class. The prepared reference material in the Appendix is designed to help you, as is the Bibliography where greater detail is required.

The methods present a variety of ways in which the students can find the answers to their problems. Develop the plans in such way that the students make their own discoveries from the available material. When they learn the conclusions from their *own* investigations, the results will have much more meaning for them.

It may be that interest and creativity in a given class run so high that new and additional methods of inquiry are presented by the students. This should be encouraged.

Whichever method(s) is used, the "Understandings" state the minimum concepts which the students should develop as a result of investigating the problem.

PART III

SOME MOTIVATING TECHNIQUES

In planning to teach about venereal disease the teacher should bear in mind his goal — to help create an attitude of intolerability toward VD and to help provide students with the necessary information toward this end. He stimulates his students to recognize the need to be informed in this area and prepares them to receive the proposed learning experiences.

The following list of suggested motivating techniques presents a variety of ways in which the teacher might stimulate the student to want to learn what is important about venereal disease and its control.

This list is by no means exhaustive and substitutions may suggest themselves to the teacher. If time is short and interest is sufficiently high the teacher might start right in with the problems in the following sections, and reduce the time taken for motivation. However, the suggestions which allow for pupil questions help to keep the teacher aware of the students' problems. This should be encouraged throughout the unit.

If one or more of the following techniques are to be used, the teacher, after reading them all, makes his choice based upon what he knows about his students and upon the amount of available time. References are frequently made to the Appendix where the teacher might find necessary information or suggested sources for such information.

1. The class may already be aware of VD as a problem. Before this topic is taught suggest that the students write anonymous questions pertaining to VD which concern them or someone else and drop them into a selected receptacle. One teacher using a teapot suggested that the class "keep the pot boiling" all term long.

2. Role-playing could be utilized to reveal many problems of young people. The teacher could write a series of short synopses on slips of papers. The number of students required to act out a "scene" is selected and the students perform extemporaneously. This is followed by class discussion, eliciting different patterns of behavior and attitudes, as a result. Some synopses might be: "You promised your parents you would be home by eleven o'clock. You return at 1 A. M. There is a scene." "You promise your mother that you will not drink. You go to a party and everyone is drinking. Your escort says come on join the crowd."

   You might present these as an example of synopses and invite the students to contribute their own anonymous ones. Acting these out would reveal patterns of behavior and attitudes which should be taken into consideration in the teaching of this unit.

3. The "Inner Circle." In this "game" some six or seven students who wish to discuss a relevant problem amongst themselves, yet do it out loud, seat themselves up front, or inside a circle. Only those students participate. The rest of the class benefits from hearing others discuss problems which they may recognize to be their own. Next time one of the onlookers might become a participant. The teacher suggests the kind of problem as a a model, and then the "Inner Circle" takes that one or suggests one of their own. The problems would be similar to the synopses suggested in number 2 (above).

4. Show the film, “The Innocent Party.” Anonymous questions stimulated by the film can then be solicited.

5. Arrange a bulletin board with posters and pamphlets on VD. Although the term “VD” may be new to some students, the history of venereal disease is old. Some historians quote evidence in support of the belief that syphilis and gonorrhea are as old as the human race; others have collected evidence which indicts the sailors who returned with Columbus from their famous voyage for transporting syphilis. A brief review of the history of syphilis could be made. (See Appendix).

6. Reference to VD appears in literary works. Sometimes it is the theme of a play, a story, or a poem, and sometimes there is just passing reference to it. One source which might be discussed is Ibsen’s “Ghosts”. However, references to VD also appear in Shakespeare’s “Love’s Labour’s Lost” and “All’s Well That Ends Well”, Marlowe’s “Dr. Faustus”, Voltaire’s *Candide,* and others. Since literature reflects the health, history and social climate of the time the discussion can be centered about this core. (See “Some References to VD in Western Literature” in Appendix).

7. “To know syphilis is to know history”. This statement, by William F. Schwartz of the Venereal Disease Branch of the U. S. Public Health Service, refers to historical figures whose lives were so affected by syphilis, that this in turn affected the course of history. Some of these people might be investigated by interested students. Among them are:

   Henry VIII—England
   Christopher Columbus of Italy
   Charles VIII of France
   Frances I of France
   Ivan the Terrible of Russia
   (See “VD and History” in Appendix.
   This article is followed by a selected bibliography.)

8. The status of VD more recently, in the 1930’s, could be discussed with Thomas Parran’s book, *Shadow on the Land* for reference. Note that this book preceded the use of penicillin.

9. Figures on the increase of venereal disease could be given to students without telling them the disease. Let them graph the material from their local area and study the trend. When this is done, reveal the disease is increasing so rapidly at present. (See Appendix and also Problem I.)

PART IV

PROBLEMS

It is not enough to keep revising scientific information in order to bring it up to date. It is equally important to revise the methods of presenting scientific data. Teaching encompasses more than a presentation of a body of established facts. We must not represent any phase of science as a body of irrevocable truths since these "truths" are constantly being changed. It is this element of change which must be understood and appreciated.

Teaching by introducing problems and guiding the students in the solution of these problems results in learning the necessary scientific facts, together with an understanding of the kinds of processes in which scientists engage as they seek to understand our world. It is this continuous inquiry which results in changing concepts.

The problems which follow can each be solved in a number of different ways. Several solutions are suggested for each problem. The teacher may find one or more suitable for his class. Stimulating discussion may lead to an entirely new method of solution. It is in such activity that teaching is most exciting and most creative. In fact, new solutions should lead to new problems which should lead to new solutions and so on.

Thus, when the teacher engages in teaching as inquiry, he succeeds in presenting both the facts of science as they stand for the moment, and an appreciation of the methods of science as they lead to new facts tomorrow.

PROBLEM I. WHY IS THERE AN INCREASE IN VENEREAL DISEASE TODAY EVEN THOUGH THERE ARE KNOWN CURES?

SUGGESTED METHODS OF PROCEDURE:

1. Discuss headlines, such as the following, noting their date, varied source, content where appropriate. (See Appendix for reprints).
   a. "Another Epidemic of Teen-age VD?" by Celia Deschin, *Ladies Home Journal,* March, 1963.
   b. "What Parents Must Know About Teenagers and VD" by Dr. Leona Baumgartner, *McCalls,* January, 1963.
   c. "Resurgent Syphilis: It Can Be Eradicated", *Time,* September 21, 1962.
   d. "Syphilis Cases Rise", *The New York Times,* Sunday, May 6, 1962.
   e. "Once More — VD", by George Kent, *Parents' Magazine,* March, 1961.
   f. "VD — Growing Threat to Youth", *Reader's Digest,* October, 1958.

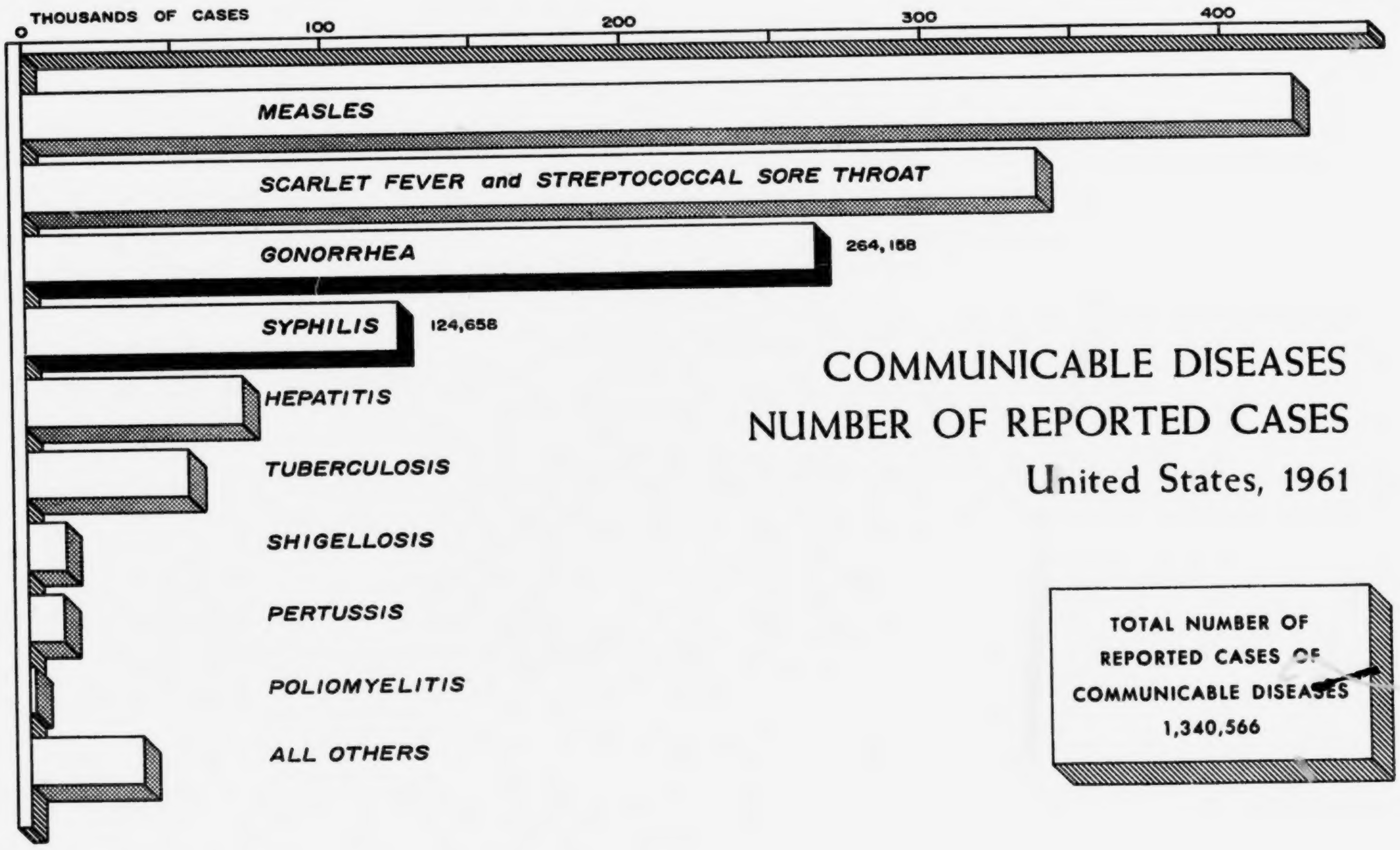
2. Discuss statements such as these, being made at present. Alert the students to find similar ones and report them.
   a. "Venereal disease is today a serious and worsening problem, threatening to sweep the country like a forest fire." Dr. Leona Baumgartner former New York City Health Commissioner.
   b. "Even more shocking than the marked increase in infectious syphilis is the fact that the greatest increase has been among young persons." Dr. Howard A. Rusk.
   c. "The incidence of venereal disease is again on the rapid rise, particularly among teenagers." From the President's message to the White House, "Youth and Physical Fitness," February 14, 1963.
   d. "The rise (of VD) is absolute in every category across the country—male and female, poor and rich, young and old, negro and white, urban and rural." Dr. William S. Brown, chief of the VD Branch of the U. S. Public Health Service. *Reader's Digest,* March, 1961.
   e. "Here is a disease (syphilis) which should be easy to eradicate with the tools we have today. That it is now only surviving but flourishing in its present proportions is a fact in which none of us can take pride, and in which we must all, as responsible citizens, be alarmed." Dr. William J. Brown, Speech to Kings County Medical Society, March 21, 1963.
   f. "In recent syphilis epidemics nearly half of the persons involved were under 20 years of age. Every day 148 cases of venereal disease are reported among persons under 20 years of age. This is one child or teen-age case every 10 minutes."
   A statement by the Public Health Service.

3. Discuss the fact the TV programs such as these are featured:
   a. April 22, 1963, "VD: Teenage Trouble."
   b. May 30, 1963, "Field of Battle", a dramatization of today's syphilis problem. This was an episode in the series, "The Nurses."

4. How does VD compare with other communicable diseases?
   a. Below is a graph of nationally reported communicable diseases for 1961 which can be used as a basis for discussion.
   b. In 1962 a young person with smallpox traveled through New York on his way to Canada. Over 6,000 people rushed to be vaccinated the following day. No panic or

notable mention was made of the fact that 3,300 new cases of syphilis were reported in New York City that year. How do you explain this difference?

c. A comparison can be made between the incidence of VD and of other communicable diseases such as polio. The amount of money spent on controlling these diseases might also be compared. (See Reprint, "Syphilis Cases Rise", in Appendix).



COMMUNICABLE DISEASES
NUMBER OF REPORTED CASES
United States, 1961

5. How prevalent is venereal disease in the U. S. as a whole?
   a. Here are some general *estimates*:
      There are over 1,500,000 new gonorrhea cases a year.
      There are over 60,000 new syphilis cases a year. Over 1,200,000 people who have syphilis do not know that they have it.
   b. Refer to the Appendix for these national data in "The Trend of Venereal Disease Among Various Age Groups." Select the figures of the age group which is of interest to the class and plot them on graphs. Discuss the trend. Note that these are *reported* figures and are probably underestimated. It is thought that the correct number is at least 3½ times more. Some estimates indicate that there are between 200,000 and 300,000 VD cases a year for persons under 19. This means that on an average there are 600 new cases each day — about one new teen-age VD case every 2 minutes!

6. Discuss the following excerpts concerning VD in New Jersey, taken from the "New Jersey State Department of Health VD Fact Sheet".

   "Infectious syphilis cases in New Jersey have increased 1200% since 1956. During the past year 1219 cases were reported. In New Jersey 40% more new infections were reported in 1962 than in 1961".

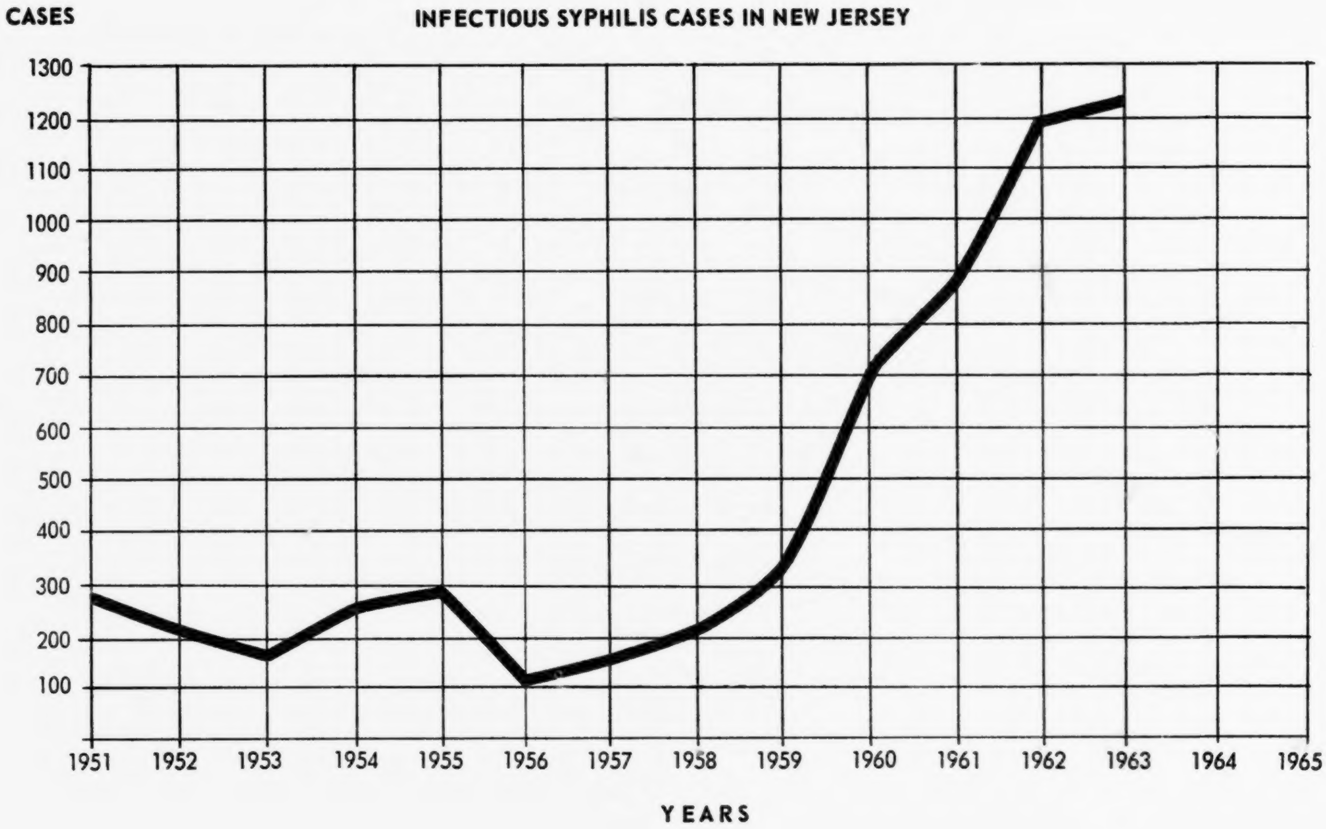
   Teachers should use current tables of data so that this will be updated annually.

   "Only seven other states had more cases of infectious syphilis in 1963 than New Jersey."

"Forty-one percent of New Jersey's infectious syphilis in 1962 was among people in the age group 15-24 years."

"Two-thirds of New Jersey's syphilis problem occurred in the 6 largest cities in the state." (See "Some New Jersey statistics on VD" in Appendix)

7. What is the prevalence of VD in New Jersey?
   a. The accompanying graph can be duplicated and distributed. Allow room for continued entries. The trend can be discussed.
   A similar graph may be made for gonorrhea with the information obtained in the Appendix. ("Some New Jersey Statistics on VD") One graph may be superimposed on the other in order to study the comparison.



8. How prevalent is VD among young people in New Jersey who are of the same age group as the members of the class?
   a. Refer to the Appendix for "Civilian Cases of Primary and Secondary Syphilis by Age in New Jersey: 1958-1962" and for similar data on gonorrhea. Discuss the prevalence of these diseases at the specific age levels represented in the class. Compare to data for 1963, (see Appendix)
   b. Comparisons of the prevalence of VD between this group and groups of other ages can be made (41% of New Jersey's infectious syphilis in 1962 was among the 15-24 year age group. (See "Venereal Disease Cases by Age Group, 1962" in Appendix)
   c. Graphs may be used for emphasis.

9. How many cases of syphilis and gonorrhea are reported in our community?
   a. Information can be obtained from "Syphilis and Gonorrhea Cases by Counties and Major Cities, Numbers and Rates, New Jersey, 1962" (Appendix) Compare to data for 1963, (see Appendix)

   b. These numbers can be compared to New Jersey as a whole (see #7 above) and also to the nation as a whole (see #5 below).
   c. The class might estimate what the rate is per 100,000 population, since this is how most of the statistics are presented.

10. Dr. Thomas Parran, who, when he was U. S. Surgeon General, started effective VD control measures, stated (1937):

    > It cannot be repeated too often that first and foremost among American handicaps to syphilis control is the widespread belief, from which we are only partially emerging, that nice people don't have syphilis, and nice people shouldn't do anything about those who do have syphilis.

    In the light of this statement, and present-day attitudes, show the film "A Respectable Neighborhood". Although there are many approaches in this film, discussion can be centered around what is meant by "respectable" and emphasis should be on the fact that VD among young people is becoming more prevalent and invading all kinds of homes and neighborhoods; it is no longer relegated only to slums and delinquent youngsters. (It is important for teachers to preview this film.)

11. Graphs and figures arranged in a sequence which demonstrates the rapid rise of VD, with emphasis on its increase among teen-agers can be projected on a screen.
    a. A series of graphs and statistics on filmstrip would be useful when available.
    b. A series of such material could be collected and shown through an opaque projector. Sources for this material could be the statistical material supplied in the Appendix as well as other references mentioned in the Bibliography.
    c. A set of kodachromes could be made from the material, and used for the same purpose.

UNDERSTANDINGS:

VD is an important problem about which young people should be concerned.

VD is increasing in all geographic areas and in all kinds of neighborhoods.

Newspapers and magazines have been carrying articles emphasizing the seriousness of the rising number of VD cases, especially among teenagers. Television has also had programs dealing with problems of VD.

Since 1957 the number of cases of infectious VD (gonorrhea and syphilis) has been rising very rapidly.

The number of nationally reported cases of infectious syphilis is three times what it was in 1957. It is estimated that because of inadequate reporting, the number of cases most recently reported is closer to 600,000. (1962). For 1963 the estimate is thought to be closer to 817,000.

There is an increase in VD in New Jersey, too.

The most alarming development is the tremendous increase in VD among the 15-19 year age group and the 20-24 year age group.

VD is increasing in "good" neighborhoods and among young people from "respectable" homes.

There is considerable evidence from statements by reputable people that there is great concern over rising VD.

PROBLEM II. WHAT IS VENEREAL DISEASE (VD)?

SUGGESTED METHODS OF PROCEDURE:

1. If the reproductive system has already been studied, a brief review of the organs and functions of that system would be helpful.
   For those who have not had this previously a lesson should be devoted to survey this system of the body. (See #10 and #18 in the Bibliography.)
2. A brief survey of high points about VD may be made, such as:
   a. VD stands for venereal disease. The name venereal comes from the Roman goddess of love, Venus.
   b. The two most common venereal diseases are syphilis and gonorrhea.
   c. Important facts about syphilis and gonorrhea.
      (1) Causes
      (2) How transmitted
      (3) Signs and symptoms
      (4) Whether it is hereditary
      (5) Course of the diseases
      (6) Treatment and cure
      (See notes in appendix for information. For greater details see #22 in Bibliography.)
   d. If the class is studying communicable diseases, and syphilis and gonorrhea are included, the same outline which is used for any disease is useful for VD. Thus, another outline, and in greater detail, might be:
      (1) Trends in morbidity (the rate)
      (2) Trends in mortality (deaths)
      (3) Is one age level attacked more than another?
      (4) How disease is spread
      (5) Causative organism if known
      (6) Control of disease
      (7) Diagnostic test
      (8) Possible immunization
      (9) Early symptoms
      (10) What a person with early symptoms should do
      (11) What people who are associated with this person should do
      (12) Treatment in general
      (13) Research now being carried on.
3. If time and interest indicate that information concerning other venereal diseases is desired, such material can be obtained and reports made. (See Bibliography #21.)
4. Distribute and discuss several pamphlets, such as "Everyone Should Know." (See Bibliography.)
5. Pictures of the effects of syphilis at various stages, particularly of early stages may be shown.
   a. A filmstrip, when available, could be used.
   b. Pictures in back of the book *Syphilis* (See Bibliography #22) could be used under an opaque projector or made into kodachrome slides.
6. A number of simple procedures can be used to grow a variety of bacteria. These can be demonstrated under a microscope and will give the students an idea of shape and size.

a. Obtain some dry weeds or grass. Place in water which has been warmed to about 70 degrees Farenheit. Allow to remain in a dark place seven to ten days. This should result in rod-shaped bacteria, both motile and non-motile, as well as round and spiral forms.

b. Put a few slices of raw potato into a glass of warm water to which 3-4 tablespoonfuls of molasses have been added. After several days a variety of bacteria can be seen under the microscope.

c. Examine some yogurt under the microscope. Dip a toothpick in a little yogurt and spread thin on a slide. Cover with cover glass. Examine under low power, then under high. Look for round and rod-shaped bacteria.

d. The spirochete which causes syphilis is very similar in its appearance to a harmless spirochete found in the mouth. To see the spirochetes in the mouth, scrape between the teeth with a clean toothpick. Place a drop of water on a slide and add the scrapings to it. Add a little nigrosine (an inexpensive stain obtained from biological supply houses*). Spread the stain with the toothpick. Allow to dry. Examine under the microscope. The bacteria will look light against a dark background.

e. Dig up a clover plant with its roots. Wash the soil off the roots. Look for little bumps. This is where the bacteria are found. Place a few nodules (bumps) on a clean slide. Crush them. Add a drop of crystal violet stain (easily obtainable from biological supply houses*). Mix for 30 seconds. Wash off gently. Blot with a paper towel. Examine under the microscope.

*One source is:
General Biological Supply House
8200 South Hoyne Avenue
Chicago 20, Illinois

UNDERSTANDINGS:

There are several venereal diseases.

Syphilis and gonorrhea are the two most common ones.

Both diseases are highly contagious and spread very easily from one person to another. They are not contracted from door knobs, toilet seats, towels, air, food, water, or physical strain.

Syphilis is spread from one person to another by sexual relations or, rarely, by other close physical contact such as kissing people who have the disease at a time when there is a break in the skin which comes in contact with the germs.

Syphilis can be spread by sexual contact among people of the opposite sex or by people of the same sex.

Gonorrhea is spread by sexual relations too.

A person may have both diseases at the same time.

A person may be cured from syphilis or gonorrhea and catch it again. A cure does not mean one is immune or "safe."

There is no vaccine against syphilis or gonorrhea. (See Appendix, "Information on Syphilis and Gonorrhea").

The diseases are not hereditary; i.e. there is no gene for syphilis or gonorrhea. Each disease is caused by a different germ which enters the body. If a pregnant woman has the disease the syphilis germ can pass into the baby's blood from the mother and cause the baby to be born a syphilitic. This is known as congenital syphilis. The baby can be infected by the germs of gonorrhea as it is being born.

The signs of syphilis are:

> First, from one to six weeks after exposure a small sore appears at the place of infection. This chancre (shanker) may look like an open sore, a pimple, or a blister. It is not painful. It is usually found in the genital area but may be found on fingers, between toes, on lips, or breasts. Sometimes there is no sore at all. Sometimes it is not visible when it is inside a woman's sex organs. It may take up to 3 months for a sore to appear. This is the primary stage. The sore goes away by itself but not the infection. Germs are multiplying in the blood and spreading. From three to six weeks after exposure, and even up to six months, the secondary stages appear. This is the most contagious stage. A rash appears. It may be localized on hands and feet or it may cover the body generally. It may look like a food reaction but unlike a food rash the syphilis rash causes no itching. Sores may appear in the mouth. Hair may fall out in patches. Fever, sore throat, and headaches may develop. If there are sores in the mouth, the disease may be passed on by kissing an uninfected person who has a break in the skin where kissed. By six months all symptoms disappear, even without treatment. The person may feel fine. But the germs continue to multiply and invade the organs. Syphilis can be treated at any stage.

The signs of gonorrhea are:

Pain and a burning sensation in the sex organ upon urinating (man or woman). Drops of pus appear there too. A woman may be unaware of these signs in herself and she can pass the disease on to others without realizing that she has gonorrhea.

Gonorrhea can cause heart trouble, arthritis, blindness, and sometimes death.

Babies born from a mother with gonorrhea may be born blind.

The disease can be treated at any stage.

The bacteria which cause gonorrhea and syphilis are similar in appearance to many harmless forms. Only an expert can tell them apart.

PROBLEM III: WHAT SHOULD YOU DO IF YOU HAVE VD OR IF YOU THINK YOU HAVE VD?

SUGGESTED METHODS OF PROCEDURE:

1. Where can one go? Besides going to a private physician, there are health clinics. Discuss why it is unwise to treat one's self.

2. Discuss what a visit to the physician would entail.

   a. Some students could get this information from doctors whom they know.

   b. This is an area where a physician could be called in to explain such procedure to the class* and to explain that whatever information is given to the doctor is confidential. (Confidence is required by law.) In advance of the doctor's visit, the students should be encouraged to prepare questions they may have. These can be sent to the doctor before his visit.

   c. Show the film, "The Innocent Party" in which procedure in a doctor's office can be viewed.

3. The cause of syphilis, Treponema pallidum, can be seen only under a "darkfield" microscope. Reference to this is made in the literature and in some of the films. Those students who are interested in this can find out more about darkfield magnification and report to the class. (See #20 in Bibliography.)

   Some understanding of how cutting down the light increases the visibility of some organisms can be shown. Put a drop of live protozoa under the microscope, using bright light, with diaphragm fully open. Advise the students to cut the light down by closing the diaphragm, and also by using the plane mirror instead of the concave mirror on the microscope.

4. Why does the doctor take some blood when he examines you?

   a. The various blood tests are quite involved, but if students are interested there are several good explanations. (See Bibliography #12, 19, 21, 22.)

   b. When sores are present the doctor examines some of the material from the sore because the germs of syphilis are in the sore.

   c. The germs of gonorrhea are in the pus which can be easily collected from the male organ but which are deeper in the body in the female.

5. A discussion of immunity and antibody reaction would be helpful. The body develops reactive antibody material called reagin in response to a syphilis germ invasion into the body. Serological tests are based upon the presence of reagin. (See #19 in Bibliography.)

   There are no blood tests for gonorrhea.

*The New Jersey chapter of the American Women's Medical Association has volunteered to go to schools.

UNDERSTANDINGS:

Since the symptoms of syphilis disappear even if untreated, self-medication does not mean a cure and should never be relied upon.

Only an examination by a doctor can tell you for sure whether you have VD.

All records and information obtained by physicians and case workers pertaining to VD are kept confidential.

Whether or not a person feels anything the syphilis germs multiply in the blood, and cause an antibody to develop (reagin) which only a blood test can reveal.

Verification of the germs which cause syphilis and gonorrhea can be made only by an expert, and with special laboratory equipment.

The germs which cause syphilis and gonorrhea live and multiply in the body of a person infected with the disease whether the person does or does not have any signs which he (or she) sees or feels. Conditions outside the body are so unfavorable that soap and water can destroy syphilis germs. Unfortunately, soap and water cannot wash off gonorrhea.

There are free public clinics where people can go for treatment of venereal disease if one cannot afford to go to a private physician. It is important to go and it is urgent to go at once.

PROBLEM IV: HOW CAN VD BE CONTROLLED?

SUGGESTED METHODS OF PROCEDURE:

1. What provisions should an effective VD program have?
    a. First, what important facts about VD and the world in which we live should we bear in mind before we discuss controls?
    Review such facts as the rapid increase of VD, with emphasis on the highest increase being among teenagers; VD is spread quickly and our world is in constant motion — cars, trains, planes, with increasing numbers of young people driving cars; there is earlier dating, earlier going "steady", less adult supervision of young people; VD is caught from people who are infected, principally by sex contact; there is no self-cure and symptoms disappear while the germs continue to develop in the body; only medical help can recognize and treat VD; there is no immunity after one is cured.
    b. Secondly, what kind of steps should be taken for an effective VD control program, and by whom?
    c. Finally, explain current control methods. (See Bibliography #16 and #17, "Practices in the Control of VD" in *Today's VD Control Program.*) Include those provisions made by law which are designed to protect uninfected people from VD.
2. Discuss case-finding and contact the interviewing as two current methods. Develop the importance of revealing the names of contacts. (See "Practices in the Control of VD" in the Appendix.)
    a. A trained case worker might be asked to address the class, and explain his work. To get such a speaker, contact your local health clinic.
    b. Diagrams of syphilis outbreaks can be distributed. Copies of the cases in the Appendix could be used. One way to handle this might be?
        (1) Distribute the diagrams.
        (2) Ask "what impresses you first?" (Number? Size of outbreak? Location? Date? etc.)
        (3) Proceed to investigate various aspects, such as the number of teenagers involved, the number of males, females, the results.
        (4) Discuss conditions which might have led to these tragedies and how they might have been prevented.
    c. Reports on cases can be given by students and discussed. (See "Three Cases of Syphilis Outbreaks" in Appendix.)
    d. The work of a contact interviewer can be seen in the film, "A Respectable Neighborhood." Call attention to the "web" of contacts shown, and ask the class to discuss what is meant by "Each case stops a possible epidemic." The process of "cluster testing" could be discussed here as means of "catching" a missing contact. This is done where there is a prevalence of VD. An infected person will be asked not only who his sex contacts are, but who among his friends or in his place of employment is likely to have similar experiences. This has helped in the tracking down of infected people who might have been overlooked otherwise.
3. What are the patterns of today's teenage behavior which lead to VD and how might they be changed?
    a. The reprint, "Another Epidemic of Teenage VD" is used in the following procedure (Reproduced in Appendix). Make enough separate copies of each of the 3 following sections for each student. Omit the title (The teacher may read the material instead of duplicating it, but the latter is more effective. The teacher might also prefer to omit reference to family names, even though ficticious.)
        (1) Distribute Section I only. The class reads it silently.

SECTION I

What do parents do when a loved child, a "good child who never gave us a moment's trouble," contracts a disease that "nice people don't have"? Here is how two typical families met the problem many are faced with today. We'll call them the Walkers and the Rosses.

The Walkers live in a comfortable home on an attractive street in a pleasant suburb. Their oldest child, 15-year-old Joan, is in high school. She is pretty, popular, and this year, for the first time, she has been going steady. Her parents have not been happy about this. They have felt that she is too young. But Jack Ross, 17, comes from a "nice" family too. And, like millions of other parents, the Walkers and the Rosses have found it hard to argue down that teen-age cry, "Everybody else goes steady!"

When the telephone rang in the Walker house one afternoon, Mrs. Walker answered in her usual cheerful tone. But as she listened, her face paled. The caller was a doctor, not their family physician, but one whose name was known to Mrs. Walker. "It must be a mistake, doctor," she protested. "It can't be my daughter. What is she doing in your office?"

The doctor assured her that Joan was in his office. She had been brought there by Jack. Jack suspected that he had contracted syphilis and had exposed Joan to it. Tests had confirmed his suspicions. Would Mrs. Walker permit Joan to be examined?

Convinced that what he was saying was impossible, Mrs. Walker managed to say, "I'll be there right away. She drove to the doctor's office, trying not to think through the implications of what he had said. Joan could not be involved in anything like this. But Joan's white, frozen face told her that there had been no mistake. Mrs. Walker could not bring herself to look at Jack or speak to him.

The doctor asked Jack to wait outside and told Mrs. Walker the story Jack had told him. It was not, he said, an unusual story: A group of boys in a car, some drinking, a pickup of several girls from another suburb. None of the boys had met the girls before, and (they said) would not recognize them again. One of the girls said, "My mother and father are away. Why don't we all go to my house?" They picked up some beer, and at the house there was more drinking. Sexual intimacies grew out of half-drunken goading and taunts of "don't be chicken!"

Joan had not been at the party. But later Jack discovered that he had contracted syphilis, and might have infected Joan. He asked her to accompany him to the doctor's office. There, hearing the whole story for the first time, Joan was too upset to telephone her mother. She asked the doctor to do it.

It would be necessary to examine Joan and make some laboratory tests, the doctor went on. Did Mrs. Walker prefer that it be done by their regular family doctor? It was Joan who said no to this. She did not feel that she could go through the painful, humiliating explanation again.

When the examination was finished, Mrs. Walker asked to speak to the doctor alone. "What can we do?" she asked helplessly. "Is Joan going to be all right?"

The doctor outlined the treatment Joan would require if tests proved positive. It was simple and effective. Since Joan had sought medical help so early, there should be no lasting harmful effects. Then he added bluntly but kindly: "I have teen-age children of my own, Mrs. Walker. I know how you feel. If I were you, I would not ask Joan too many pressing questions right away.

Joan is deeply shocked. She feels frightened and guilty. She cannot bring herself to admit that she has had sexual relations with Jack, though Jack admitted it to me privately. Joan insists that they just 'petted heavily.' But she will tell you the truth, I'm sure, if you do not arouse her resentment with too many questions and accusations. Believe me, it will work out better in the long run." He concluded: "I will telephone you as soon as I have Joan's laboratory reports."

Mrs. Walker nodded, thanked him for his kindness, and left the office. In the car she patted Joan's hand with a calmness she was far from feeling. At home, Joan went silently to her room and stayed there for the rest of the afternoon. Remembering the doctor's advice, her mother fought back the questions she wanted desperately to ask. One question, however, would not be stilled. Joan's father had to be told. How was it to be done, and who was to do it? Joan decided that. She would tell him herself, after dinner when the younger children were in bed.

It was not an easy story, and it was not told without tears and hesitations. But Joan told it. This shocking and bitter experience taught her a lot, she said. "A lot that I should have known—did know really." As they listened, heartsick, her parents realized that they, too, were hearing things they should have known—had known, really. Their failure had been in not using their knowledge to protect their daughter.

Joan admitted having sexual relations with Jack. "He said it was all right, we were going steady. It was just proof that I loved him. If I didn't love him, there wasn't much point in our going steady, was there?" Mrs. Walker remembered protesting only a few weeks ago. Why had she let herself be argued down when she knew she was right?

The first time was here in their own house. Joan went on. "You and mother went out to play bridge," she told her father. "Jack and I were listening to records. We had argued about . . . things before, and I knew how it would be, so I hoped you wouldn't go out."

It happened several times after that in Jack's car. "I wasn't ever happy about it," Joan said. "I knew it was wrong. I talked to other girls about it, and most of them felt it was wrong too. But nobody knew how to say no. The boys wouldn't want to go steady any longer if we said no." Her tone told them what a serious, humiliating loss of status this would have been among her contemporaries.

When the class has finished reading the excerpt, discuss whether such things really happen. Encourage the students to talk about the attitude expressed by Joan.

(2) Distribute Section II. Class reads it.

SECTION II

That night Joan and her parents drew up a set of what they called House Rules. It listed clearly and simply what was expected of Joan, from household tasks to the number and kind of dates she could have and the time she must be home. All parties at the Walker house would be chaperoned, and Joan would attend no unchaperoned parties at homes of friends. "I'll talk to the other mothers in the neighborhood." Mrs. Walker said, "If we all agree on certain standards of behavior—and stand firm—the children won't be able to gang up on us with that 'every else does it!' cry."

It was agreed that Joan had a right to expect certain things from her parents. More thoughtful, serious attention to questions that troubled her, for one thing. And more effort to be good examples of the sort of person they wanted her to be. They would also try to make clear to her the standards and values which they would most like to have her hold.

A little to her surprise, Joan's friends were enthusiastic when they heard about the House Rules. "It's a lot easier when you know what your parents expect of you," one said honestly. "Most of the time they just say, 'Be good," without ever telling us how to be good, or just what 'good' really means to them."

Jack and his parents worked out their own set of rules, as each family must, since no single formula could possibly be successful for all. But the first and most important step toward success was made when they faced the problem honestly and together.

After class has read Section II, discuss whether this is a good way to go about solving the problem. The class members should suggest rules of their own. Let them discuss the consequences of suggested solutions.

(3) The class then reads the rules developed by the family portrayed in the article in Section III which is distributed.

SECTION III

Adolescents need to know what behavior is expected of them, especially in the area of sex. Parents should provide this guidance. Accurate sex and health education in schools could help protect children against VD. (In the New York City teenage VD study which I conducted, 64 per cent of the teenagers said that all of their information about sex and venereal disease came from friends their own age. They displayed pitiful ignorance of even the most basic facts. Only 10 per cent knew what VD is, and that it is almost never contracted except through sexual intercourse.) People who oppose sex education in schools argue, "If you teach a child about sex, he'll be out experimenting with it!" I would say that the exact opposite is true—the more accurate information a child has, the less likely he is to get into trouble. True knowledge does not corrupt, it protects.

Parents should limit the number of dates a teen-ager is permitted and set a definite time for coming home. They should be at home and visible when their teenagers entertain.

Parties (at home, in schools, churches, teen-age clubs, and so on) should be chaperoned by responsible adults. Adolescents may complain, but they really do feel more secure with adult guidance and supervision.

Have the students compare these rules to the ones they recommended previously.

The students might be advised to discuss this with their parents and report the next day if they wish to do so.

A scheme of canvassing the student body might be developed, and the resulting rules published in the school newspaper if there is a strong feeling that such rules are useful.

What might prevent the formation of neighborhood rules from operating successfully?

Show the film, "Dance Little Children." This portrays the situations which exist among teenagers (even in "respectable" neighborhoods, among "nice" young people) that encourage the kind of behavior that leads to VD.

(1) Discussion:

The value of this film lies in the discussion which follows. Some questions might be:

(a) What might the parents have done to prevent the tragedy? How would you react if you were the parents?

(b) To what extent are the young people at fault? What should the girl who is anxious for the boy's attention do under the circumstances?

(c) How might the future happiness of these people be affected by their youthful behavior?

(d) Could the school have helped? What might the school have done which could have prevented the trouble?

(2) It is possible that many unresolved and controversial questions will develop following the discussion. A set of questions which the class might like to put to the entire student body could be drawn up.

The class might then shown the film or dramatize the film as a play, perform it at a school assembly, and arrange for student response to the questionnaire.

4. Correct information is one of the best aids to controlling VD. Students should pass on correct information to others. One good way to handle this is to review what they know by posing the ten most frequently asked questions concerning VD. (See Bibliography #1.) After this discussion, plans may be developed for the class to design a leaflet for general distribution.

The questions follow:

(1) How do you get VD? (It is contagious and is caught by sexual contact with an infected person).

(2) Can you get it from kissing? (Yes, but rarely. If a person has patches in the mouth from a VD infection, and there is a break in the skin of the other person, one may catch VD this way).

(3) Can you get it from petting, contact with clothing, toilet seats, towels, doorknobs, drinking fountains, utensils? (Practically never—the germ is very fragile and lives in moist, warm tissue).

(4) How do you know when you have it? (Only the doctor can be sure. You can suspect syphilis and gonorrhea by certain signs (see Appendix) but labaratory tests are necessary to be certain. When suspicious, see the doctor quickly).

(5) Is it curable? (If caught early, penicillin cures completely; if late, damage may not be repaired but ravages can be stopped. One should go for treatment no matter when, but the earlier one goes, the more certain he is of a complete cure).

(6) Why is it serious? (Syphilis can affect the heart, eyes, lungs, bones, and nervous system, producing insanity. It can cause deformed offspring, or the baby of a syphilitic mother can be born dead. Gonorrhea may result in sterility, arthritis, blind babies).

(7) *Is VD found among low income groups, in slums principally? (No. It is found all* over. [See quotation by Dr. Brown, Problem I, "Suggested Method of Procedure" #2].)

(8) What should you do if you get syphilis or gonorrhea? (See a doctor. Self-cures do not work. Symptoms disappear but the germs remain, multiply, and spread. You can go to a private physician or to a clinic).

(9) Does penicillin have after-effects? (No. However, some people are sensitive to penicillin and the doctor will have to use other antibiotics).

(10) If you have syphilis and/or gonorrhea, and you are cured, can you catch it again? (Absolutely. One can become reinfected time after time. There is no vaccination against VD, and no immunity develops as a result of having had VD).

5. How did scientific discoveries affect the study of venereal disease? (See "Some Scientific Contributions" in the Appendix).

6. Show the film, "The Invader" which traces the history of the disease, and points out how it can be controlled. Students can be advised that the following questions will be discussed.

a. How did syphilis affect history?
b. Why did syphilis spread rapidly in the 16th and 17th centuries?
c. How did earlier scientific discoveries make it possible for later scientists to discover the germ, the test, then the cure of syphilis?
d. What contributions were made by Schaudinn, Hoffman, Wasserman, Bordet, Ehrlich, Parran, Fleming, Mahoney?
e. How was knowledge about syphilis and its cure kept from people?
f. What were the Rapid Treatment Centers?
g. What evidences can you find to indicate that the film was more optmistic than the present situation justifies?

7. How can we get the parents interested in VD control?

a. Show the play, "You Never Told Me"* at a PTA meeting. This play is about VD and teenagers. It explains how VD "can happen" to *anyone's* child, and how the family must share responsibility for VD education. The script has directions for production, and a list of questions at the end for guiding discussion.
b. A speaker from one of the organizations involved in VD work could be invited to address the parents. (Contact local VD clinic.)
c. Select one of the films appropriate to your area. Precede a discussion on VD with the showing of the film.
d. Have a meeting with parents where such problems as the following are discussed:
    (1) How should parents inform their children about VD? At what age? Is it true that "ignorance is bliss?"
    (2) How can parents develop the kind of relationship which builds confidence between them and their children so that it is easy to advise the children to keep out of trouble, and it is also easy for the children to come to their parents if they do get into difficulties?
    (3) How might TV, radio, movies, newspapers, books, paperback books, and teenage oriented advertising be related to the present VD epidemic?

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*Copies of this script may be obtained without charge by writing to: The Bureau of Public Health Education, Department of Health, 125 Worth Street, New York 13, New York.

e. Discuss the present trends in VD.

(1) When the national VD program was started in 1939, over 1400 people were reported to have died from syphilis. In 1962 the number was 4000. It is thought that homosexuals are contributing considerably to the increase of VD.

(2) The number of newly admitted mental cases due to syphilis declined from 7,800 in 1939 to 1,663 in 1955.

(3) The infant deaths due to syphilis decreased markedly.

(4) The number of syphilis cases which were reported up to 1954 declined.

(5) But, since 1954, the trend is reversing:

Discuss the national and local statistics. See Problem I and Appendix for information, stressing the high incidence in New Jersey as compared with other states and the tremendous increase in VD among teenagers. (See Appendix "Syphilis and Gonorrhea Cases by Counties and Major Cities, Numbers and Rates, New Jersey 1962 and also for 1963.")

(6) Read the following excerpt from a speech made at the New York Academy of Medicine on March 10, 1964 by Dr. William J. Brown, Chief U.S. Venereal Disease Branch: " . . . today it is costing American tax-payers fifty million dollars a year to care for the victims of syphilitic insanity and another six million dollars for care of the syphilitic blind. And so, in view of the fact that it (Syphilis) is eradicable—that we have the tools to eradicate it—it would seem that its eradication is long overdue."

UNDERSTANDINGS:

States have certain laws which are designed to protect healthy people by requiring blood tests before marriage, during pregnancy, and in certain occupations.

Scientific advances in medicine reduced the period of treatment of VD from months to single injections.

Everyone has to contribute to VD control—the individual, the local community, the state, the nation, the world. All must cooperate.

Continued funds and on-going campaigns are needed to eradicate VD.

It is essential to name every sex partner to a case worker who is making contact investigations because VD spreads so quickly.

The "web" of VD can spread rapidly to other states and other parts of the world because we move so quickly.

If certain patterns of sex behavior and ideas of sex among young people were changed there would be less VD among teen-agers.

Every young person should spread correct information about VD, its dangers, and its control to others. Correct information is one of the most powerful tools for controlling VD.

Parents could help with proper VD education at home.

PART V

EVALUATION

One way of looking at the effectiveness of such efforts as suggested by this unit on venereal disease would be the ultimate eradication of syphilis. This is a large order. While this is the ultimate purpose of the work, there are also other activities which require our continuous concern. These have to do with some specific purposes in teaching the unit in the first place. Let us assume that teachers attempt to accomplish the following types of purposes.

1. To promote an accurate understanding of the nature of venereal disease.
2. To help young people develop wholesome attitudes toward their own bodies, boy-girl relationships, and home and family problems.
3. To develop an awareness of the role of various community agencies active in various phases of the task of identification and control of venereal disease.

In order to evaluate growth of young people in basic understandings, a variety of evaluative techniques might be employed.

1. Discussion questions which require ability to draw upon basic principles taught in order to answer the question.
2. Emphasis on interpretation of data. Present the student with specific figures of the extent of venereal disease in the city, county, and state. Make a series of statements about the data which are true, another series which are false, and a third series of statements about which insufficient data was provided.
3. In a test situation ask the students to summarize their information in terms of broad conceps or understandings.
4. Make it possible for students to prepare a series of sketches or charts which portray important aspects of the venereal disease problem at the present time.
5. At the beginning of the unit ask students to define key words. Allow them to hold their paper and put it in a sealed envelope. Put the name of the student and the date on the front of the envelope. At the completion of the unit repeat the same procedure. Make it possible for the students to compare his two papers.
6. Complete a sentence test. Identify the key words which you consider basic to the understanding of the venereal disease test. Ask students to write a sentence about each word to see if his understandings are accurate.
7. Create an arrangement in which the students who have had the unit on venereal disease have an opportunity to arrange a panel to be presented to a group of students who have not had this study. Tape record their panel. Enable them to listen to their tape and identify inaccuracies and gaps in the information.
8. Assessment of attitudes.

   Much of the effectiveness of the work on veneral disease is attitudinal. Prepare a list of statements to which students respond. Illustrative statements are —

a. Only poor people get syphilis.

b. Syphilis is secured from door knobs, toilet seats and drinking glasses.

c. Many people have bad blood.

d. The best way to avoid venereal disease infection is to make certain that one keeps his body clean and gets the proper diet.

e. Sex contact is one way of getting a venereal infection.

f. The present venereal disease problem was brought about because there are so many soldiers and sailors traveling over the world.

g. There is no relationship between illegitimacy and venereal disease.

h.

i.

j.

It is suggested that after a list of about fifty statements have been prepared ask the students to respond in terms of whether or not they *agree, disagree* or are *uncertain* about their beliefs about each of these statements. Upon analyzing the data a teacher can determine whether or not students' beliefs are accurate or whether they are inaccurate. Attitudes reflect knowledge and values. It is suggested that the results of such a test would be helpful to the teacher in planning ways of relating to young people in terms of their attitudes. The same test might well be given at the end of the unit to find out if any change has occurred.

9. Opportunities for individual work.

As the unit is taught it would seem that it would be helpful if students could be motivated to engage in a variety of different kinds of writing. One student might write an editorial dealing with the venereal disease problem in the State. Another might write an editorial on wholesome recreation for young people. At other times the students might prepare a chart describing the nature of the organisms. A summary of the work of the local Health Department in venereal disease control might be described as the basis for showing understandings of the role of public health commissioners. Students might be given opportunities for panel discussions, open forums, and interviews concerning their questions in the area of venereal disease.

APPENDIX

INFORMATION ON SYPHILIS AND GONORRHEA

SYPHILIS

CAUSE:

Syphilis is caused by a spirochete (a form of bacteria) called Treponema pallidum. It is a long slender spiral organism which is difficult to see. It is very fragile and cannot survive outside of the moist warm body.

SIGNS:

First stage (Primary syphilis). A sore appears at place where germs entered the body, usually the sex organs. This sore may appear anywhere from one to six weeks after exposure.

The sore may last about one month. This sore, called a chancre (shanker) sometimes is so small as to be hardly noticeable. Sometimes it looks like a blister or open sore. In girls it may be hidden inside the sex parts and not be seen at all.

Whether or not it is treated the sore disappears but the germs are living and multiplying in the blood and organs.

Second stage (Secondary Syphilis). This is the most contagious stage of syphilis. Three to six weeks after the first sore all or some of the following symptoms may occur; a rash (large or small) on any part of the body; patches of falling hair; sores in the mouth; fever; sore throat; headache. These signs will go away too, but the germs are increasing in number, are getting into the body organs, and can infect other people.

EFFECT:

If the infected person goes untreated damage continues, and in 5 to 25 years insanity, blindness, heart disease, paralysis, various deformities may develop.

Although the disease is not inherited the germ passes from an infected mother's blood to the baby if the mother has syphilis during pregnancy. The baby may be born blind or deaf or of low mentality. This can be prevented if the mother is treated early in her pregnancy, and even up to within five months.

CURE:

Penicillin is a sure and quick cure if used early. It is helpful at any time, however.

Even though cured, people can become reinfected time after time. There is no immunity.

It is considered that the first year is most infectious. Emphasis is therefore placed on primary and secondary syphilis. For information concerning latent syphilis, late syphilis, congenital syphilis, syphilis which affects the nervous system or heart, or further details, see Bibliography (#20, 21).

HOW TO TELL IF IT IS SYPHILIS:

In the early stages of syphilis - primary and secondary - a doctor can take scrapings from the sores. He can look at these under a special microscope and actually see the syphilis germ. After the sores have gone away, the only way to tell is by having a blood test. So it is important to have a blood test at least once or twice a year, just to be sure.

GONORRHEA

CAUSE:

Gonorrhea is caused by a small round bacterium which appears in pairs.

SIGNS:

Itching and burning of sex parts is noticed a few days after infection. This burning is felt particularly while urinating. A discharge also develops at about the same time. Girls may sometimes not notice these symptoms even though they are infected. Signs and symptoms may clear up without treatment, but this does not mean a cure. The germs are still in the body, multiplying and causing harm.

EFFECTS:

The germs can damage the sex glands of boys so that they are unable to become fathers. The sex organs of girls can become damaged so that they are unable to have children. Babies born to mothers with gonorrhea can become blind at birth. Untreated gonorrhea can result in arthritis and heart trouble.

CURE:

Penicillin can cure gonorrhea. In order to prevent damage cure must be given early.

HOW TO TELL IF IT IS GONORRHEA:

If a person thinks he or she has gonorrhea, it is best to go to the doctor or public health clinic at once. The doctor will take a small smear of the pus from the sex parts with a cotton swab and put it on a special dish. This dish will be kept in the laboratory for a few days until the germs grow thickly enough so that they may be found. They will then be stained and examined under a microscope. Then the doctor will be able to tell for sure if it is gonorrhea. Sometimes, this test is not necessary for men, because the germs grow so thickly in the man's organ that often they may be easily found and examined at once.

Gonorrhea is so highly infectious and has such a short period of incubation that it is very difficult to find and treat people who might have had contact with a person infected with gonorrhea.

As of the present moment, the techniques for diagnosing and treating gonorrhea are not completely adequate, especially in women.

VACCINES

Many people underestimate the importance of present methods of preventing VD because they think that the development of vaccines are imminent. At present the development of vaccine against either syphilis or gonorrhea is remote.

The syphilis-causing organism stimulates the body of an infected person to produce antibodies. These antibodies do not provide lasting immunity. This explains why a person who is cured from syphilis can become reinfected when exposed to the germs again.

However, the fact that the body does produce antibodies offers hope that a vaccine may be developed. Researchers are seeking a substance (known as an antigen) which, when introduced into the body, will produce lasting immunity against syphilis. This type of antigen has not yet been discovered.

Right now the experimenters are at the very first stage of their research. Their initial problem is how to get large quantities of the syphilis germs to grow in flasks so that experiments can be conducted. However, these delicate organisms cannot yet be grown successfully outside the human body.

As far as a vaccine for gonorrhea is concerned, the situation appears even more hopeless. Gonorrhea does not activate the body to the production of any antibodies. So far no vaccine has ever been developed against a disease which is caused by an organism which does not stimulate the body to produce antibodies.

Since the development of vaccines is so remote at present they cannot be considered as a means of prevention against venereal diseases.

REPRINTS OF ARTICLES ON VD

A study of 600 adolescent patients in social hygiene clinics . . .

TEENAGERS AND VENEREAL DISEASE

CELIA S. DESCHIN

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RECENT INCREASES in venereal disease among adolescents in the United States—a rise of 130 percent in reported cases from 1956 to 1960—make it imperative to clarify our own as well as the young people's attitudes toward sex; to replace ignorance with knowledge, and community apathy with appropriate action; and to take a critical look at the laissez-faire attitude of some public health authorities toward physicians who do not report the venereal disease patients they treat in private practice. The history of medicine makes it clear that attitudes toward disease have constituted significant factors either in facilitating or impeding control. Therapy alone—even when effective—has not proved sufficient to control disease unless supplemented by education and by appropriate changes in social institutions and in human behavior.[1]

With this in mind the American Social Health Association in cooperation with the New York City Department of Health undertook a study of the attitudes of teenaged venereal disease patients for the Public Health Service, U.S. Department of Health, Education, and Welfare. Begun in September 1958, the study was completed in March 1961. It involved interviews with 600 teenagers attending the social hygiene clinics of New York City, and visits to the homes of 100 of them.

Although the study was designed to include the patients of private physicians as well as of clinics, too few of the former were referred to the study to make any comparisons possible. This was a reflection of physicians' traditional reluctance to report their patients—a major factor in hampering efforts toward eradication of the disease and in preventing precise calculation of how many teenaged patients there may be in the nonclinic population.

Some preliminary field work indicated that venereal disease patients, including teenagers, were treated as if the disease existed apart from a human being. To be sure, the patients were urged to return should they become reinfected. However, a clinic policy of moral neutrality can be misinterpreted by the young patient as a quasi-acceptance of the sexual activity through which he has become infected.

At the time the study was initiated, little was known about the teenaged venereal disease patients in New York City. As director of the study, I was warned by both social hygiene clinic personnel and social workers in community agencies dealing with problems of youth that such teenagers were "delinquents" from demoralized families with little potential for rehabilitation and that they would certainly not talk to adults about their sexual behavior or related aspects of their lives. It was suggested that young interviewers be engaged and some form of payment be provided to the interviewees.

Not entirely convinced, I did some exploratory interviewing in one of the city's social hygiene clinics in a district health center where the physician in

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Dr. Deschin was director of the teen-age study conducted by the American Social Health Association.

charge did not share these stereotyped views. From the beginning, the response of the teenagers was friendly, interested, and cooperative, despite some initial resentment at having to prolong a visit to the clinic that sometimes took up to 3 hours, because of the unavoidable delays common to busy, walk-in clinics. Similar cooperation was subsequently met by the study interviewers—all of them adults who were trained and experienced social workers. In order to obtain 600 voluntary interviews, we had to approach 610 teenagers. Only 3 of the 10 refused outright to be interviewed; 5 were persuaded by persons close to them not to participate in the study; and 2 withdrew. Word soon got around that the study was a "Junior Kinsey" and that the interviewers were "OK." No one was paid and the teenagers were told that any results could not come soon enough to be of direct benefit to them. Where problems were revealed with which they or their families needed help, referrals were made through the charge nurse to appropriate agencies. The young people seemed eager to make a contribution to the study.

The Interviews

In each interview the objectives of the study were outlined briefly and simply and the importance of accuracy was stressed. The young people were given an opportunity to withdraw at any point if reluctance or serious inconsistencies were noted. The interview schedule, which was evolved during the exploratory interviewing, took from an hour to an hour and a half to complete. The teenagers were asked to provide data concerning their socioeconomic and cultural backgrounds; family status; education; religious affiliation and church attendance; leisure-time activities; employment; sexual activities, knowledge, and attitudes; feelings of guilt or religious conflict concerning their behavior; self-evaluation; and social adjustment, ranging from evidence of socially deviant behavior, sexual included, to their identifications with adults, their goals and self-images.

Parents accompanying teenagers to the clinics were interviewed as were parents in their homes.

The social workers involved in the interviewing were given training in research. The confidentiality of the information obtained in the clinic interviews was protected by having the home visits made by a social worker who did not do any clinic interviewing. In view of the limited knowledge available concerning the teenaged venereal disease patients and the unpredictability of the flow of patients in the clinics, we decided to interview all who came to the clinics during the period the primary data were being collected—February through August 1959. This means, of course, that the findings cannot be generalized until validated or invalidated by follow-up studies in New York with nonclinic patients and by comparable studies elsewhere.

Essentially an effort to determine factors contributory to the increase in venereal disease among adolescents, the study was designed to answer questions pertinent to the epidemiological aspects of control, including the following:

What kinds of teenagers are involved in venereal disease?

From what kinds of families and social backgrounds do they come?

From the above flowed a variety of specific questions. One was:

Are there significant differences in their social behavior depending upon their social background as a whole; or depending upon age, ethnic group, religion, family stability, education, employment, self-image, aspirations, and adult indentifications?

A question of a general nature, included to bring out some of the extrafamilial influences that conceivably might be having an influence on both teenagers and their parents, was:

Are there trends in 20th-century American life that tend to exert pressure on the adolescent toward premarital sexual experimentation?

In the final report of the study,[2] this question is answered in the affirmative on the basis of a comprehensive analysis of the kinds of stimuli and social sanctions which induce young people to experiment sexually in the absence of comparable stimuli toward experimentation in nonsexual activities.

Findings and Implications

Who were the teenagers and from what kinds of families did they come? To what extent did identification of both fit the prevailing stereotypes?

While it is not possible here to describe findings that cover four chapters in the published report,[2] some significant findings and implications can be highlighted.

While all the teenagers interviewed had had sexual relations, only 63 percent were found by the clinic to have had one or more venereal infections. Of these, 70 percent were boys; 30 percent, girls. Among the infected group, numbering 379 teenagers, 159 reported 1 previous infection; 55 reported 2 or more.

Promiscuity, defined as casual, frequent, and depersonalized sexual relations, was a predominantly male phenomenon in the study universe. It was determined on the basis of number of sexual partners, length of time the teenager had been engaging in sexual activities, and personalization of the partner. The 600 teenagers—aged 12 through 19—were more evenly divided between boys and girls, 352 and 248, respectively, than the differences in promiscuity reflect. Only 2 girls were in the most promiscuous group as against 60 boys, while 5 times as high a proportion of the girls than of the boys were in the least promiscuous group. While society's greater acceptance of promiscuity among males may have occasioned some exaggeration on the part of the boys and some underreporting on the part of the girls, there is little reason to believe that this appreciably affects these comparisons.

Homosexuality was also much more prevalent among boys, with only 9 girls so involved out of a total of 115 teenagers who reported homosexual activity.

Tabulations to check the reliability of responses, checks for consistency, and the information obtained in the home visits confirmed the interviewers' impressions that the teenagers provided essentially accurate data—subjective as well as objective. Additional confirmation of interpretation of the differences in promiscuity between the sexes is to be found in correlations showing that promiscuity among the males was not significantly related to socially deviant behavior while it was so related among the females. It should come as no surprise that promiscuity correlated significantly with venereal disease, especially among the boys.

Exploded Stereotypes

Although nonwhites accounted for 71 percent of the universe, Puerto Rican teenagers, 16 percent, and other whites, 13 percent, promiscuity was found in all three groups with no essential difference. Contrary to a prevailing stereotype, the white teenagers were the new residents in the city. A majority of the nonwhite and most of the Puerto Rican patients were either long-term or lifetime residents of the city. In some instances physicians in the clinics failed to inform white teenagers about the research interview, and these were not, therefore, included in the study.

A majority of the young people interviewed came from low-income, minority group families. However, only one-sixth were dependent, in part or in whole, on public assistance. More than one-sixth of them came from families of lower middle-class status, and 28 percent from families with middle-class aspirations. Their social class status was confirmed by the home visits and by indices of parental control. For example, over two-thirds of the teenagers reported that their parents were interested in knowing where they went, expected them to be home at a certain time, and set standards for their behavior even if unable to insure that these were carried out at all times.

The stereotype of demoralized families with little potential for rehabilitation does not stand up under the study's findings. Most of the parents who were interviewed expressed concern over the behavior which had resulted in their child's illness, though often they did not seem to know about other socially deviant aspects of his or her behavior. The social worker who interviewed parents in their homes encountered requests for help and many evidences of a desire to improve their situations. For example, there were many indications of attempts to transform slum apartments into attractive, livable homes.

More than three-fourths of the teenagers interviewed—79 percent—were over 16 years of age; 62 percent were 18 or 19 years old. In religion, 62 percent were Protestant; 32 percent were Catholic; 2 percent were Jewish; the remainder were either unaffiliated or belonged to miscellaneous religious groups. Almost half the young people reported that their parents attended religious services, while slightly more than 25 percent of the teenagers themselves did so.

The educational and cultural levels of most of these young people can only be characterized as impoverished. While nearly 75 percent had entered high school, only 15 percent had graduated. Few reported any use of New York City's neighborhood libraries and the cultural opportunities available in the schools and in community centers. However, 3 percent were attending college.

The major school problems reported were lack of interest in subjects, reading difficulties, failure to achieve promotion, and lack of interest on the part of the teachers. As one teenage girl put it: "My teacher would sometimes say, 'I get paid whether you learn or not. I don't have to teach you!'" This girl, like many of the other teenagers, had been involved in truancy before becoming involved in sexual activities. Repeated truancy was reported by 80 percent.

Of the 439 teenagers not in school when interviewed, only 176 had had any work experience, part or full time.

The teenagers revealed their concerns over lack of a meaningful role in answers to questions designed to get at their self-image. When asked what they did in their spare time, 509 replied: "Nothing!" This is not in contradiction to their having indicated that they spent some time in recreational and other types of activities—including sexual; it is a frank—if somewhat devastating self-appraisal. Having nothing to do—in the sense of having few meaningful and socially useful responsibilities—means essentially to be nothing. To what extent this lack of role and the resultant *anomie* may be related to promiscuity can only be raised as a question for further investigation.

Social Controls and Behavior

Despite the availability of techniques for mechanically processing research data, relating social controls to behavior is still a major problem for the social sciences. The status of today's knowledge of human behavior and its interaction with environment calls for caution in interpreting statistical associations, especially in an exploratory study. Because of this and the subjective nature of interview data, probability levels were set high in the tests for statistical significance, and reservations were made in the interpretation of correlations.

Many of the indices of social control generally regarded as having an influence on behavior reflected significant relationships to promiscuous and socially deviant behavior, with variations according to sex and ethnic group. Among these indices were: psychological atmosphere of the home (rated as favorable if the teenager spent considerable time there, took his friends there, and did things with his family); teenagers' religious attendance; whether or not the teenager lived with his family; and whether or not the teenager was still in school. School status reflected the most statistically significant influence.

Attempts at classifying the teenagers as living in a "favorable" or "unfavorable" environment were unsuccessful, since most of them lived in environments having both favorable and unfavorable aspects.

Educational level correlated significantly with what was rated as a very good knowledge of the facts about venereal disease. However, only 10 percent of the young people had this kind of knowledge—not surprising in the light of the generally low level of educational attainment.

Despite their involvement in sexual activities these young people exhibited little understanding of the meaning of sex. Peers constituted the source of sex knowledge for 64 percent of these young people, while parents were the source for 21 percent; other adults, for 15 percent. Relatively fewer of the teenagers who obtained their sex knowledge from parents or adults with whom they had a positive identification were promiscuous.

Ignorance is transmitted with the same ease as knowledge. At some point the cost of the transmission of ignorance has to be weighed against the cost of improved education for parents and professional persons, as well as for teenagers.

While many of the teenagers had been involved in "delinquent" behavior, the group as a whole could not be characterized as delinquent. More than half the young people reported they had driven cars without a license and had done some stealing; 27 percent had been involved in street fighting; 38 percent had come to the attention of the police; but only 7 percent had been taken to court.

The interviewers were impressed with the frankness with which the teenagers revealed illegal actions and other aspects of their behavior that did not present them in a favorable light. They were also impressed with the frequent expressions of guilt and religious conflict.

Some Contrasts

The difficulties in establishing a typology for differentiating these teenagers, their general ignorance about sex and venereal disease, and the wide range of their behavior, both social and sexual, suggest the need not only for more education but also for greater individualization of these teenagers. Consider the contrasts in the following young people who were among those interviewed in the social hygiene clinics:

A shy, withdrawn, guilt-laden honor student of 18, who lives with his grandmother, had his only sexual experience with a prostitute to test his "virility."

An 18-year-old drug addict, who lives with both parents, has had at least 25 sex partners toward whom he feels no personal attachment. He feels sorry only for having been "caught."

A highly intelligent high-school girl, who lives with both parents, had infrequent sexual relations with her steady boy friend, but caught syphilis from him after he had impulsively had relations with a "pickup," following a lover's quarrel.

A recent arrival in New York, where she has no family ties, has gradually drifted into prostitution.

A 17-year-old girl from a closely knit family, who was goaded by her girl friends into having sexual relations with her fiance, found herself both pregnant and infected, and is in an anguish of guilt and fear for the future.

A 15-year-old boy from a broken home and a special school for problem children became infected from engaging in homosexual activity for money. He says he has no goals, does not care about anyone, and had no idea what he wants out of life.

One need all these young people had had in common was for better education about sex and venereal disease. On the surface, this should present little or no problem. The issue is, however, beclouded by emotionally charged, conflicting, and controversial attitudes toward sex in society at large, as well as among the teenagers who have contracted the disease. Constructive sex education requires a point of view and sanctions for codes of behavior to which society expects its youth to adhere. Such education should not only help to prevent the behavior which results in infection but should facilitate cooperation from the young patient in the contract interview and prevent repeated infection. It can only succeed, however, if ways can be found to involve such youth in opportunities for more education generally, the cultural life of the community, and, above all, in meaningful work and social responsibility.

Whether these implications are soundly based will, in the near future, be a matter of objective report. As a result of the study, an adolescent clinic has been initiated in the health center in which the exploratory interviewing took place. A social worker has been assigned to provide counseling and make referrals to rehabilitation agencies, and plans are underway for the provision of psychiatric services, a youth employment counselor, and courses in family life education. Moreover, even before the study was completed, changes in attitude were discernible among those responsible for operating the social hygiene clinics.

It is good to see these beginnings in a period during which it has become fashionable to emphasize man's potential for evil and to assume that control of the sex drive during adolescence is not only not essential to mature development but impossible to achieve. Teenagers like those in the study have been held responsible for conduct traceable to the failure on the part of adults to facilitate and sanction controls. Twentieth-century psychological theories that have been exploited to support sexual license, almost to the debasement of human values and personal relations, need to be reexamined if followup studies and the experimental clinics confirm the findings of this study.

In 1947 Dr. Stokes warned that even a perfect cure would not eradicate the venereal diseases since "their onset is often obscure, often invisible and nonincapacitating," and that "conduct not treatment is the key to control."[3] It is hoped that this study may stimulate more attention to the social aspects of venereal disease without which efforts at control are undermined. Stokes' warning and Scheele's statement more than a decade ago that "what is needed is increased research on the part of those in psychiatry and the social sciences to determine the factors underlying the spread of venereal infection and the social deviations related to their spread,"[4] are even more pertinent today.

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[1] Deschin, Celia S.: The relation of socioeconomic and cultural factors to an understanding of illness, Ph. D. dissertation. Center for Human Relations and Community Studies, New York University, 1958.

[2] Deschin, Celia S.: Teenagers and venereal disease; a sociological study. American Social Health Association, New York. March 1961. Reprinted by the U.S. Department of Health, Education, and Welfare, Public Health Service, Communicable Disease Center, Venereal Disease Branch, Atlanta, Ga.

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MEDICINE

Resurgent Syphilis: It Can Be Eradicated

Only five years after syphilis had apparently been conquered in the U.S. and was rapidly declining elsewhere, "the great pox" is making an unexpected comeback. For the past two weeks agitated experts attending the World Forum on Syphilis and the International Congress of Dermatology in Washington have heard shocking estimates of the ravages of revitalized syphilis:

▶ Of 106 nations reporting to the World Health Organization, no fewer than 76 have a rising incidence of syphilis.

▶ In the U.S. the number of cases is still increasing. In the fiscal year that ended June 30, more than 4,000 babies were born with syphilis and at least 4,000 Americans died of it. There were also 124,188 cases reported for the first time. But only 20,084 of these were truly new (in the infectious primary or secondary stages of the disease), and these probably represented only half of the actual total. Almost 20,000 cases had gone unreported (and therefore, usually, untreated) for up to four years, and 80,000 for an even longer period of time.

▶ A staggering 9,000,000 Americans are estimated to have syphilis, or to have had it at some time in their lives; probably 1,200,000 are now suffering from untreated syphilis.

Frail Germ. What makes these woeful numbers so astonishing is that syphilis is completely preventable, and in its earlier stages is completely curable with inexpensive penicillin. More remarkable, as Dr. William J. Brown of the U.S. Government's Communicable Disease Center pointed out, the spirochete of syphilis is "about as frail as a germ can be and still survive." So delicate that it can be cultivated only with difficulty in laboratory animals and hardly ever in the test tube, it flourishes nowhere but in the body of man.

Even there, the spirochete can stand so little heat that artificial fever was once a treatment for syphilis. The germ gets no free ride on food, air, water, or from insects. It can attack a new victim only through the most intimate contact, and then only during a relatively brief time. Yet during 450 years, syphilis has slaughtered and maimed millions, blinded and deafened them or driven them mad, crippled babies in the womb, and ruined the lives of millions of dependents who had no direct contact with it.

Dr. Brown hammered away at the 20,000 known new cases and 4,000 deaths annually in the U.S. If there had been only one-fourth as many cases of disease and death due to smallpox, typhus, plague or malaria, he said, there would have been virtual panic: "All the medical and public health resources of the nation would have been mustered." Why had syphilis been allowed to make such a comeback after the near knockout of the 1950s? Dr. Brown answered his own question: "As a program for the control of a disease approaches the end point, meaning eradication, it is not the disease but the program that is the more likely to be eradicated." Federal as well as state and municipal funds for venereal disease were reduced in the '50s when syphilis appeared to be beaten.

The resurgence of syphilis is partly due to a remnant of the traditional hush-hush attitude toward venereal diseases. Only 5% to 10% of today's youngsters learn anything about VD from their parents, and many learn little more in school. Teen-agers, either ignorant or overconfident, account for much of syphilis' increase. The historic spread through female prostitution has been largely replaced by spread through careless "good-time girls" and male homosexuals—especially male prostitutes.

Some doctors, said Dr. Harry Pariser of Norfolk, Va., are too much influenced by "a clean-cut appearance and an air of prosperity or social prominence" in a patient, and thus fail to order a blood test. More than a quarter-century after premarital blood-testing was adopted in Connecticut, said Manhattan Psychologist Hugo G. Beigel, "there are still several states where candidates from all over the country can be married without this precaution." In three chivalrous states only the bridegroom has to have the test.

Rapid Check. The symptoms of syphilis are so various, said Dr. Pariser, that a physician may confuse syphilis with acne, chicken pox, measles, mononucleosis or cancer. He estimated that from 40% to 60% of syphilis victims pass through the primary and secondary stages without knowing what has hit them. Then the spirochete goes underground, to erupt at intervals over the years in new active phases. Finally, in about half of the untreated cases, it attacks the heart and aorta, the brain and spinal cord. If the victim does not die of heart disease, he may end his days as a lame, blind, insane, partially paralyzed patient in a mental hospital.

The famed Wassermann test for syphilis and others like it take about two hours or more, and all require more laboratory equipment than can be toted into a backwoods area. At the Washington meetings, the U.S. Public Health Service's Dr Joseph Portnoy described a new and simplified test which its developers claim is truly portable and fast. Called the RPR (for Rapid Plasma Reagin) card test, it requires only three drops of blood, obtained by pricking the subject's finger. The blood does not have to be centrifuged or heated. After the red cells settle out, the plasma is transferred to a dimpled card, reagents are added, and the result of the test can be read with the naked eye instead of a microscope. The process takes only five to eight minutes.

Here to Stay. Even with sensitive diagnostic tests and penicillin for treatment, a massive campaign must still be waged to wipe out the disease. Doctors will be urged to report all cases of syphilis to health authorities, who will interview the patients and track down their contacts. (This has worked well in areas where health officials have made it clear that the information will never reach the police.) Laboratories, it is proposed, should be compelled to report all positive reactions. Once bitten by overoptimism, the VD crusaders are now doubly shy of any letdown. There must be no cutback in funds, they insist, until the great pox is really conquered. Dr. Brown warned that as cases become fewer, finding them will become harder—and perhaps more costly. Said Psychologist Beigel: sex is here to stay, but syphilis need not be.

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LADIES' HOME
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TELL ME, DOCTOR

Another Epidemic of Teen-age VD?

BY CELIA S. DESCHIN, PH.D.

Director of the New York City teen-age VD study conducted by the American Social Health Association.

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What do parents do when a loved child, a "good child who never gave us a moment's trouble," contracts a disease that "*nice* people don't have"? Here is how two typical families met the problem many are faced with today. We'll call them the Walkers and the Rosses.

The Walkers live in a comfortable home on an attractive street in a pleasant suburb. Their oldest child, 15-year-old Joan, is in high school. She is pretty, popular, and this year, for the first time, she has been going steady. Her parents have not been happy about this. They have felt that she is too young. But Jack Ross, 17, comes from a "nice" family too. And, like millions of other parents, the Walkers and the Rosses have found it hard to argue down that teen-age cry, "Everybody *else* goes steady!"

When the telephone rang in the Walker house one afternoon, Mrs. Walker answered in her usual cheerful tone. But as she listened, her face paled. The caller was a doctor, not their family physician, but one whose name was known to Mrs. Walker. "It must be a mistake, doctor," she protested. "It can't be my daughter. What is she doing in your office?"

The doctor assured her that Joan *was* in his office. She had been brought there by Jack. Jack suspected that he had contracted syphilis and had exposed Joan to it. Tests had confirmed his suspicions. Would Mrs. Walker permit Joan to be examined?

Convinced that what he was saying was impossible, Mrs. Walker managed to say, "I'll be there right away." She drove to the doctor's office, trying not to think through the implications of what he had said. Joan could not be involved in anything like this. But Joan's white, frozen face told her that there had been no mistake. Mrs. Walker could not bring herself to look at Jack or speak to him.

The doctor asked Jack to wait outside and told Mrs. Walker the story Jack had told him. It was not, he said, an unusual story: A group of boys in a car, some drinking, a pickup of several girls from another suburb. None of the boys had met the girls before, and (they said) would not recognize them again. One of the girls said, "My mother and father are away. Why don't we all go to my house?" They picked up some beer, and at the house there was more drinking. Sexual intimacies grew out of half-drunken goading and taunts of "don't be chicken!"

Joan had not been at this party. But later Jack discovered that he had contracted syphilis, and might have infected Joan. He asked her to accompany him to the doctor's office. There, hearing the whole story for the first time, Joan was too upset to telephone her mother. She asked the doctor to do it.

It would be necessary to examine Joan and make some laboratory tests, the doctor went on. Did Mrs. Walker prefer that it be done by their regular family doctor? It was Joan who said no to this. She did not feel that she could go through the painful, humiliating explanation again.

When the examination was finished, Mrs. Walker asked to speak to the doctor alone. "What can we do?" she asked helplessly. "Is Joan going to be all right?"

The doctor outlined the treatment Joan would require if tests proved positive. It was simple and effective. Since Joan had sought medical help so early, there should be no lasting harmful effects. Then he added bluntly but kindly: "I have teen-age children of my own, Mrs. Walker. I know how you feel. If I were you, I would not ask Joan too many pressing questions right away. Joan is deeply shocked. She feels frightened and guilty. She cannot bring herself to admit that she has had sexual relations with Jack, though Jack admitted it to me privately. Joan insists that they just 'petted heavily.' But she will tell you the truth, I'm sure, if you do not arouse her resentment with too many questions and accusations. Believe me, it will work out better in the long run." He concluded: "I will telephone you as soon as I have Joan's laboratory reports."

Mrs. Walker nodded, thanked him for his kindness, and left the office. In the car she patted Joan's hand with a calmness she was far from feeling. At home, Joan went silently to her room and stayed there for the rest of the afternoon. Remembering the doctor's advice, her mother fought back the questions she wanted desperately to ask. One question, however, would not be stilled. Joan's father had to be told. How was it to be done, and who was to do it? Joan decided that. She would tell him herself, after dinner when the younger children were in bed.

It was not an easy story, and it was not told without tears and hesitations. But Joan told it. This shocking and bitter experience taught her a lot, she said. "A lot that I should have known—did know, really." As they listened, heartsick, her parents realized that they, too, were hearing things they should have known—had known, really. Their failure had been in not using their knowledge to protect their daughter.

Joan admitted having sexual relations with Jack. "He said it was all right, we were going steady. It was just proof that I loved him. If I didn't love him, there wasn't much point in our going steady, was there?"

"Joan is too young to go steady," Mrs. Walker remembered protesting only a few weeks ago. Why had she let herself be argued down when she knew she was right?

The first time was here in their own house, Joan went on. "You and mother went out to play bridge," she told her father. "Jack and I were listening to records. We had argued about . . . things before, and I knew how it would be, so I hoped you wouldn't go out."

It happened several times after that in Jack's car. "I wasn't ever happy about it," Joan said. "I knew it was wrong. I talked to other girls about it, and most of them felt it was wrong too. But nobody knew how to say no. The boys

CONTINUED

wouldn't want to go steady any longer if we said no." Her tone told them what a serious, humiliating loss of status this would have been among her contemporaries.

Joan paused. Then she went on with resolute determination to show them that she really had learned. "Boys just try that 'prove your love' to see if it will work. Girls shouldn't be fooled by it. I don't blame Jack any more than I blame myself, but right now I don't ever want to see him again—or any other boy!"

Next day the doctor told Joan and her mother that laboratory tests were positive. Joan paled, but took the diagnosis quietly. The doctor started treatment with antibiotics immediately. "The *right* medical treatment is vital," he stressed. Sometimes teen-agers foolishly rely on 'drug-store treatment' with penicillin obtained surreptitiously. The amounts obtained this way are not sufficient to cure the disease; they only mask the symptoms temporarily." He explained that Joan would have three or four treatments, and that she would come in for regular checkups over a period of six months.

Joan asked only one question, her voice very serious. "Does this mean that when I marry I can't have babies?" The doctor assured her that it did not.

That night Joan and her parents drew up a set of what they called House Rules. It listed clearly and simply what was expected of Joan, from household tasks to the number and kind of dates she could have and the time she must be home. All parties at the Walker house would be chaperoned, and Joan would attend no unchaperoned parties at homes of friends. "I'll talk to the other mothers in the neighborhood," Mrs. Walker said. "If we all agree on certain standards of behavior—and stand firm—the children won't be able to gang up on us with that 'everybody *else* does it!' cry."

It was agreed that Joan had a right to expect certain things from her parents. More thoughtful, serious attention to questions that troubled her, for one thing. And more effort to be good examples of the sort of person they wanted her to be. They would also try to make clear to her the standards and values which they would most like to have her hold.

A little to her surprise, Joan's friends were enthusiastic when they heard about the House Rules. "It's a lot easier when you *know* what your parents expect of you," one said honestly. "Most of the time they just say, 'Be good,' without ever telling us *how* to be good, or just what 'good' really means to them."

Jack and his parents worked out their own set of rules, as each family must, since no single formula could possibly be successful for all. But the first and most important step toward success was made when they faced the problem honestly and together.

In general, the following suggestions might help:

Adolescents need to know what behavior is expected of them, especially in the area of sex. Parents should provide this guidance. Accurate sex and health education in schools could help protect children against VD. (In the New York City teen-age VD study which I conducted, 64 percent of the teen-agers said that all of their information about sex and venereal disease came from friends their own age. They displayed pitiful ignorance of even the most basic facts. Only 10 percent knew what VD is, and that it is almost never contracted except through sexual intercourse.) People who oppose sex education in schools argue, "If you teach a child about sex, he'll be out experimenting with it!" I would say that the exact opposite is true—the more *accurate* information a child has, the less likely he is to get into trouble. True knowledge does not corrupt, it protects.

Parents should limit the number of dates a teen-ager is permitted and set a definite time for coming home. They should be at home and visible when their teen-agers entertain.

Parties (at home, in schools, churches, teen-age clubs, and so on) should be chaperoned by responsible adults. Adolescents may complain, but they really do feel more secure with adult guidance and supervision.

Group activities—sports, music, drama, lectures—should be encouraged to replace the present practice of too-early dating and going steady and to discourage pairing off of boys and girls under conditions which favor sexual intimacy.

Adolescents should be weaned away from the "happiness rat race," which, after a while, becomes a bore. Work (paid or volunteer) provides happiness too. Personal accomplishment lends confidence and self-reliance.

Like the Walkers, parents should try to be good examples. They should not "preach one thing and live another." They should also try to define the standards they want their children to live up to.

On the community level, parents can work for more public-health clinics and more programs of health education. In 1957, Federal funds for these services were cut. It is no coincidence that we find 1957 the year that the VD rate began its current spectacular rise.

"Venereal disease is today a serious and worsening problem, threatening to sweep the country like a forest fire."*

In the past four years the syphilis rate in America has risen more than 132 percent. A year ago the reported number of infectious VD (syphilis and gonorrhea) cases increased to 286,466—three times the number of cases reported in 1957. Because many private physicians do not report cases of VD among their patients, health authorities estimate that the *real* total may be closer to 600,000.

Certain groups—among them prostitutes, merchant seamen, and migrant workers—have long presented special problems to control of VD. This year two new problem groups have been added to the list. The *Journal* feels that parents, to help protect their children, will want to know about both.

One problem group: homosexuals. Speaking of his city's soaring VD rate, a Los Angeles physician said recently, "There has been a phenomenal increase in homosexually transmitted venereal infections. Because the homosexual has an erroneous belief that VD is transmitted only through heterosexual relations, he seldom sees the need for VD examinations. If he does become aware that he has contracted VD, he is seldom willing to incriminate himself or his contacts by reporting it. Reporting it could mean police arrest because the practice of homosexuality is in itself a crime."

Most shocking to parents is the sharp increase in VD among the young. In one year—1959-60—there was a 59 percent increase of infectious syphilis in the 15-to-19-year-old group, a 73 percent increase among 20- to 24-year-olds; 1961-62 figures are expected to show even greater increases. And teen-age VD is no longer confined to slum neighborhoods or to juvenile delinquents. It is invading "good" neighborhoods and "nice" families.

Twenty-five years ago, Dr. Thomas Parran, then Surgeon General of the United States, made it possible for VD to be talked about openly as a serious health problem *about which something could and should be done.* He said: "It cannot be repeated too often that first and foremost among American handicaps to syphilis control is the widespread belief that nice people don't have syphilis and nice people shouldn't do anything about those who do have syphilis."

In the 1940's penicillin revolutionized treatment of VD. In the wave of overoptimism that followed, public-health funds were cut, and educational efforts were all but abandoned. Because miracle drugs had "conquered" VD forever, we no longer felt that there was a need to inform our children about it, or to teach new generations that VD can maim, blind, produce insanity, damage or destroy unborn children, cause sterility, and even kill (about 3,000 victims a year in this country).

At the same time, great changes were taking place in our American way of life, many of them designed to produce a climate in which teen-age VD could flourish. We became the most mobile nation in the world. The average American may no longer live in one home most of his life; he goes where his job takes him. His children may attend a different school every year and have a constantly changing circle of friends with constantly differing views on what is right and wrong (or "in" and "out") for their particular group. More mothers work outside the home. Grandparents—traditionally confidants and consolers of a troubled, confused child—are no longer part of the average home. Methods of communication are faster, and children are far more aware of world events. They grow up fast, start dating early. On the surface at least, they are more sophisticated. They have more money, more cars, get around more with less supervision. The word "chaperone" has become a joke. Movies, television and advertising glorify sex unrealistically. Teen-age drinking is increasing. Many traditional, once-stable roots have been swept away. Moral standards are no longer the simple, clear-cut matter they once were.

**Dr. Leona Baumgartner, chairman of a special task force appointed by the Surgeon General to investigate a recent increase in venereal disease.*

Syphilis Cases Rise

U. S. Expenditures for Disease Control Are Directly Related to Incident Rates

By HOWARD A. RUSK, M. D.

The battle against venereal disease is far from won even with such available allies as penicillin and other new therapeutic tools.

The total of 18,781 reported cases of infectious syphilis in the United States in the fiscal year 1961 was not only double the 1960 rate but triple the 1959 rate and was the greatest number reported since 1950.

Morbidity data for the first half of 1962 indicate the rate is still continuing to climb.

These figures come as a shock to most of us.

At the annual meeting of the American Public Health Association in October, 1943, Dr. John Mahoney presented a report on the successful use of penicillin in the treatment of syphilis.

Immediate Drop in Rates

Almost immediately, the national rates of syphilis and then gonorrhea began to drop. With penicillin the treatment time was reduced from months or years to days or weeks.

In 1954, when a single injection of benzathine penicillin G became the established treatment for early syphilis, it appeared that this ancient disease was ready to fall before modern science.

Even more shocking than the marked increase in infectious syphilis is the fact that the greatest increase has been among young persons.

The disease increased 59 per cent in the 15-19-year age group and 73 per cent in the 20-24-year ago group between 1959 and 1960.

The age breakdown of statistics for 1961 is not yet available, but experts anticipate that the statistics will show an even greater increase among young people than they showed the year before.

Possible Reasons Cited

Why, when it once appeared that we had victory in our grasp, have we lost the initiative?

Authorities cite many reasons. Among these are an increase in our total population and an even greater increase in our teen-age population, increase in mobility of the population, lowering of moral standards, inadequate control of prostitution, increase in the number of homosexuals, and inadequate parental control of teen-agers

Many of these complex interrelated socio-medical problems cannot be approached unilaterally. There is one factor, however, directly related to the increased incidence of venereal disease that correlates perfectly with incident rates. This is the amount of money spent by our Federal Government.

In the late Nineteen Forties and early Nineteen Fifties, when Congressional appropriations for venereal disease control were high, state and local appropriations were also high and venereal disease rates were low.

But Congress was too optimistic. Thinking that venereal disease was on its way out as a public health problem, Federal appropriations for venereal disease control were reduced. The same year, however, that appropriations went down, venereal disease rates started going up.

Increase This Year

For the current fiscal year, the Federal government has appropriated $6,000,000 for venereal disease control. This was an increase of $185,500 over fiscal 1961.

This year, the Administration has recommended an appropriation of $7,000,000 for fiscal 1963.

The House of Representatives has voted to appropriate this amount. At the same time, however, the House committee considering the appropriation expressed dissatisfaction that the Administration had not approved a request by the United States Public Health Service for $2,000,000 more in the supplementary budget for this fiscal year. Had this request been approved, a total of $8,000,000 in Federal funds would have been available for venereal disease control this year.

The Senate has not taken action as yet on the 1963 appropriation, and it is to be hoped it will voluntarily increase the appropriation.

Each year since 1954 both the House of Representatives and the Senate have voted appropriations greater than the Administration's request.

Recommendations Made

There are three major groups primarily concerned with the public health aspects of venereal disease control. These are the American Social Health Association, the American Venereal Disease Association and the Association of State and Territorial Health Officers.

These organizations have recently issued a report, available from the American Social Hygiene Association, 1790 Broadway, New York 19, with recommendations that the organizations believe can lead to a substantial reduction in venereal disease and its eventual eradication.

To achieve this the three groups urge:

¶An appropriation of $10,000,000 in Federal funds in fiscal 1963.

¶Improved case finding methods.

¶A national study of case reporting by private physicians.

¶State and local legislation requiring the reporting of all positive blood specimens by all laboratories, hospitals, and blood banks.

¶Reinstatement of routine blood tests on all hospital admissions as a requirement for hospital accreditation.

¶Expanded research in the immunology of syphilis and the diagnosis of gonorrhea.

¶Increased research in sex behavior, particularly among teen-agers.

¶Increased emphasis and expansion of education concerning venereal disease.

Rich Dividends Seen

There is no doubt that recommendations of this group, if followed, would pay rich dividends from all perspectives.

Syphilis still kills a minimum of about 4,000 persons a year. It costs $12,000,000 a year to maintain those who have been blinded by syphilis. The loss of income by men with advanced syphilis is conservatively estimated at $100,000,000 a year.

It costs $46,000,000 a year for hospitalization of syphilitic psychotics.

There are currently 4,000 veterans in Veterans Administration hospitals suffering from syphilitic psychoses. The Veterans Administration estimates the cost of care for these patients will average $40,000 each.

Of untreated syphilitics, one in 200 will become blind, one in fifty will become severely mentally ill, one in twenty-five will become severely physically handicapped, and one in fifteen will suffer severe heart disease.

The eradication of venereal disease is possible, but it will certainly not come unless we redouble our efforts medically, morally and educationally in an all-out attack on this major public health problem.

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From The New York Times, Sunday, May 6, 1962

NATIONAL AND NEW JERSEY STATISTICS ON VD

THE TREND OF VENEREAL DISEASE AMONG VARIOUS AGE GROUPS

UNITED STATES

Calendar Year	Cases less than 15 Number	15-19 Years of Age Number	15-19 Years of Age % of All Ages	20-24 Years of Age Number	20-24 Years of Age % of All Ages	Less than 20 Years of Age % of All Ages	Less than 25 Years of Age % of All Ages	All Ages Number	All Ages % Change from 1956
PRIMARY AND SECONDARY SYPHILIS									
1956	86	1093	17.1	1778	27.8	18.4	46.2	6399	0.0
1957	113	1192	18.1	1857	28.2	19.8	48.0	6581	+ 2.8
1958	113	1228	17.1	2005	27.9	18.7	46.6	7184	+ 12.3
1959	148	1668	17.0	2779	28.4	18.5	46.9	9799	+ 53.1
1960	159	2577	16.0	4692	29.1	16.9	46.0	16145	+ 152.3
1961	245	3215	16.2	5575	28.1	17.4	45.5	19851	+ 210.2
1962	265	3587	17.0	6063	28.8	18.3	47.1	21067	+ 229.2
GONORRHEA									
1956	3647	44264	19.7	74755	33.3	21.3	54.6	224687	0.0
1957	3991	43705	20.3	70777	32.9	22.2	55.1	214872	- 4.4
1958	3870	48723	20.9	76964	33.1	22.6	55.7	232818	+ 3.6
1959	3928	50324	20.9	81076	33.7	22.6	56.3	240254	+ 6.9
1960	4880	53649	20.7	87823	33.9	22.6	56.5	258933	+ 15.2
1961	4182	52131	19.7	90686	34.3	21.3	55.6	264158	+ 17.6
1962	3881	51679	19.6	91588	34.7	21.1	55.8	263708	+ 17.4
TOTAL INFECTIOUS VD									
1956	3733	45357	19.6	76533	33.1	21.2	54.4	231086	0.0
1957	4104	44897	20.3	72634	32.8	22.1	54.9	221453	- 4.2
1958	3983	49951	20.8	78969	32.9	22.5	55.4	240002	+ 3.9
1959	4076	51992	20.8	83855	33.5	22.4	56.0	250053	8.2
1960	5039	56226	20.4	92515	33.6	22.3	55.9	275078	+ 19.0
1961	4427	55346	19.5	96261	33.9	21.0	54.9	284009	+ 22.9
1962	4146	55266	19.4	97651	34.3	20.9	55.2	284775	+ 23.2

July 17, 1963
Supplied by U.S. Public Health Service

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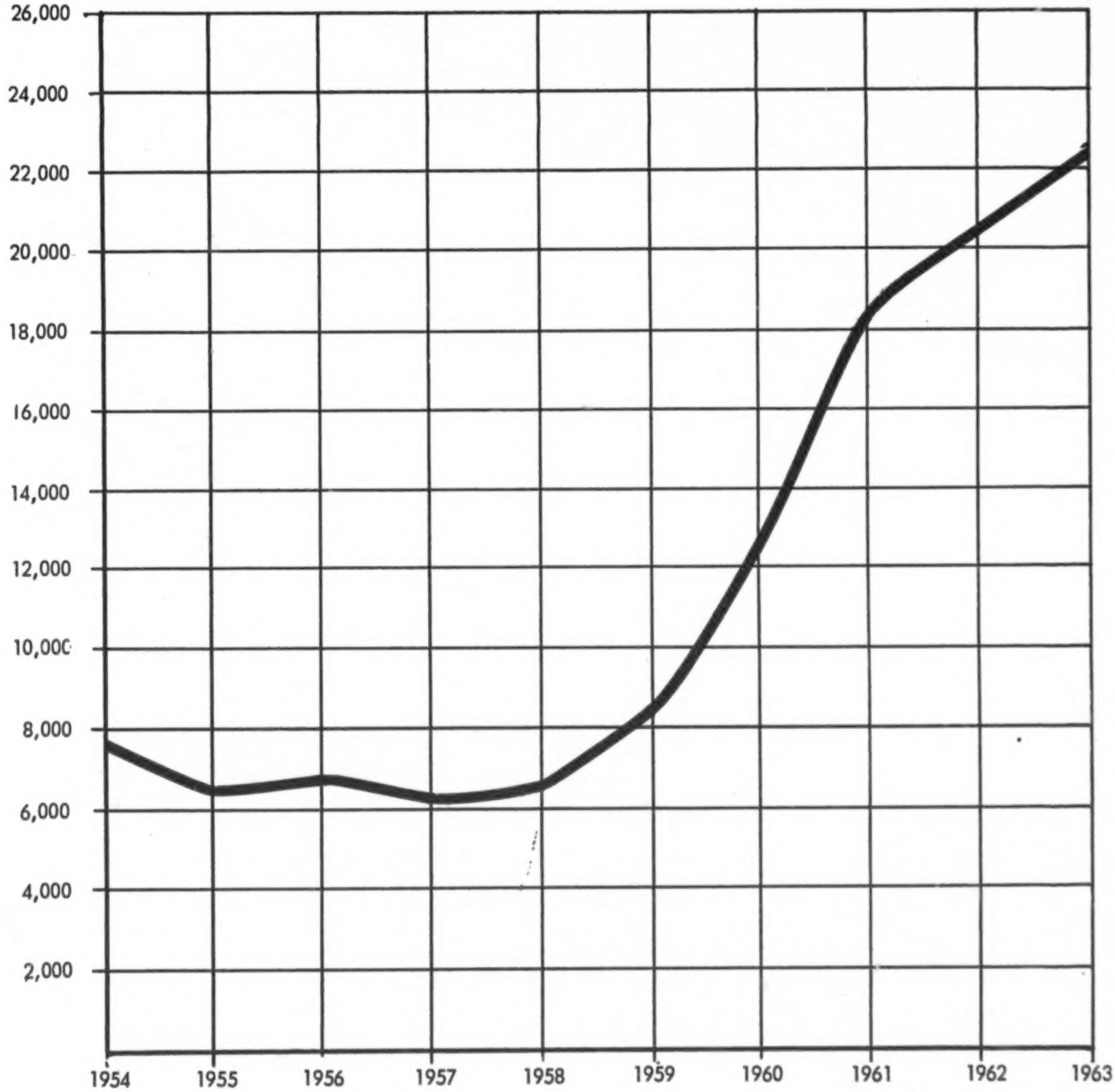
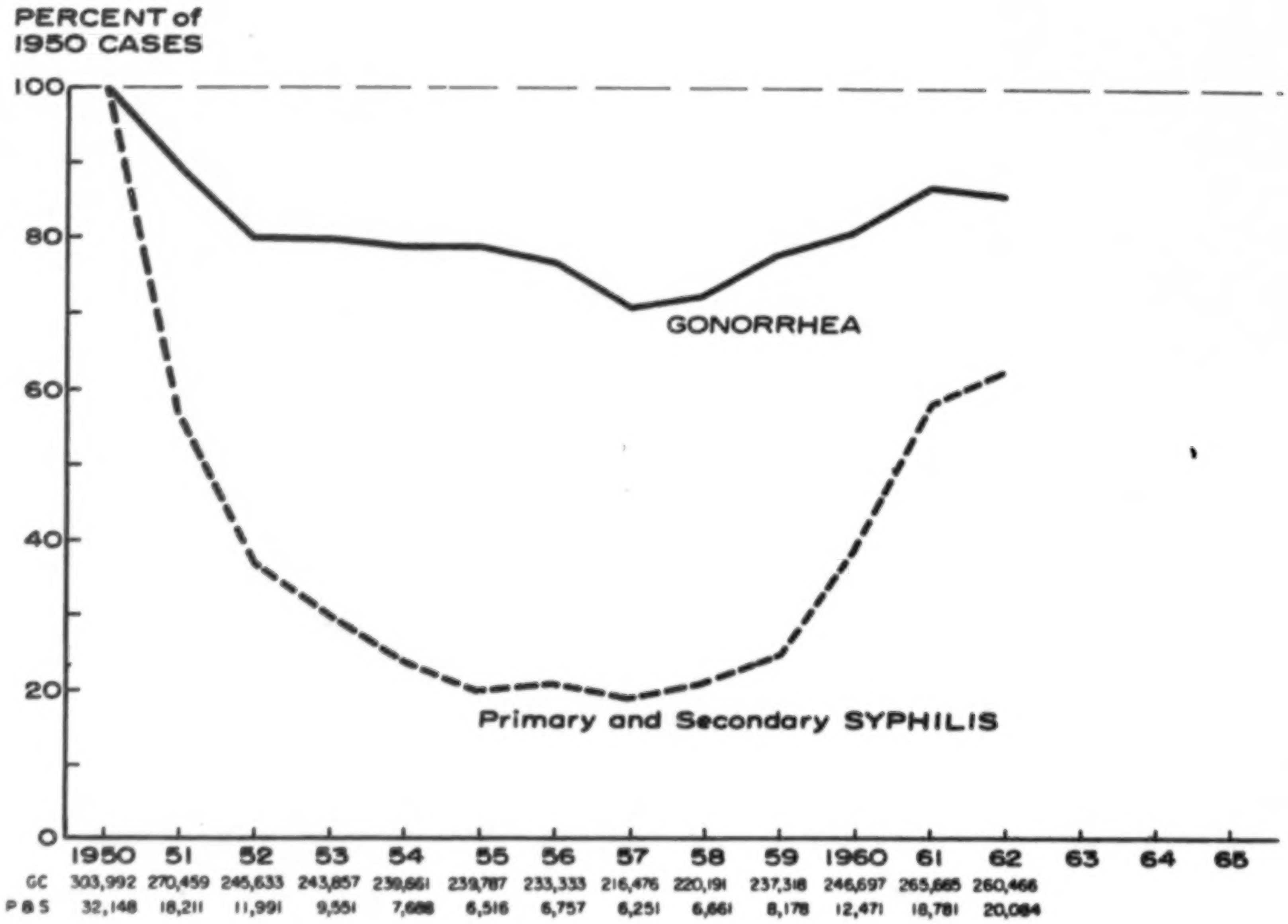
NUMBER CASES (in thousands) OF PRIMARY-SECONDARY SYPHILIS REPORTED IN UNITED STATES 1954 – 1963



CASES OF PRIMARY AND SECONDARY SYPHILIS AND GONORRHEA

As a Percentage of Cases
Reported in 1950
United States 1950-1962



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VENEREAL DISEASE CASES BY AGE GROUP, NUMBERS AND RATES: 1962

(Including Military Cases)

Age Group	Total Venereal Diseases		SYPHILIS												Gonorrhea		Other Venereal Diseases	
			All Stages		Primary and Secondary		Early Latent		Late Latent		Late		Congenital					
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
All Ages	10,443	164.6	6,325	99.7	1,219	19.2	870	13.7	3,715	58.6	319	5.0	202	3.2	4,085	64.4	33	0.5
Under 1	2	1.4	1	0.7									1	0.7	1	0.7		
1 - 4	22	4.0	4	0.7	2	0.4							2	0.4	18	3.3		
5 - 9	23	3.7	1	0.2					1	0.2					22	3.5		
10 - 14	65	11.3	20	3.5	15	2.6	4	0.7					1	0.2	45	7.8		
15 - 19	949	226.5	308	73.5	164	39.1	94	22.4	28	6.7			22	5.3	634	151.3	7	1.7
20 - 24	2,271	723.2	735	234.1	334	106.4	224	71.3	144	45.9	7	2.2	26	8.3	1,532	487.9	4	1.3
25 - 44	4,170	238.4	2,477	141.6	617	35.3	443	25.3	1,256	71.8	54	3.1	107	6.1	1,677	95.9	16	0.9
45 - 64	1,939	141.1	1,861	135.4	56	4.1	70	5.1	1,550	112.8	157	11.4	28	2.0	76	5.5	2	0.1
65 +	684	114.6	676	113.2	10	1.7	4	0.7	576	96.5	85	14.2	1	0.2	7	1.2	1	0.2
Unstated	318		242		21		31		160		16		14		73		3	

Note: Rates are per 100,000 estimated population.

Prepared by the Public Health Statistids Program, New Jersey State Department of Health, February 28, 1963.

CIVILIAN CASES OF SYPHILIS BY STAGE AND GONORRHEA,

NUMBERS AND RATES per 100,000 estimated population: 1944-1963

YEAR	POPULATION ESTIMATE	SYPHILIS						GONORRHEA	
		TOTAL CASES		PRIMARY & SECONDARY		EARLY LATENT			
		Number	Rate	Number	Rate	Number	Rate	Number	Rate
1944	4,167,840	8,664	207.9					3,094	74.2
1945	4,200,941	8,901	211.9	1,317	31.4	2,694	64.1	4,892	116.5
1946	4,304,261	9,881	229.6	2,010	46.7	3,453	80.2	6,468	150.3
1947	4,435,000	8,735	197.0	1,670	37.7	3,138	70.8	6,449	145.4
1948	4,729,000	8,352	176.6	1,182	25.0	2,978	63.0	4,069	86.0
1949	4,786,000	7,795	162.9	771	16.1	2,511	52.5	4,449	93.0
1950	4,832,000	5,838	120.8	360	7.5	1,768	36.6	3,933	81.4
1951	4,989,000	4,016	80.5	228	4.6	1,125	22.5	3,559	71.3
1952	5,112,000	3,846	75.2	180	3.5	1,029	20.1	3,596	70.3
1953	5,236,000	3,742	71.5	168	3.2	1,005	19.2	3,682	70.3
1954	5,359,000	5,285	98.6	184	3.4	1,175	21.9	3,761	70.2
1955	5,482,000	4,854	88.5	214	3.9	1,095	20.0	4,150	75.7
1956	5,605,000	4,263	76.1	92	1.6	578	10.3	3,828	68.3
1957	5,728,000	5,429	94.8	114	2.0	462	8.1	4,789	83.6
1958	5,851,000	6,055	103.5	170	2.9	638	10.9	5,493	93.9
1959	5,974,000	4,863	81.4	302	5.1	609	10.2	4,646	77.8
1960	6,098,000	5,265	86.3	665	10.9	752	12.3	4,778	78.4
1961	6,221,000	5,170	83.1	864	13.9	721	11.6	4,302	69.2
1962	6,344,000	6,291	99.2	1,191	18.8	864	13.6	3,557	56.1
1963	6,467,000	5,613	86.8	1,177	18.2	756	11.7	3,968	61.4

Note: Data for 1944 through 1956 include all New Jersey resident cases plus all nonresident cases diagnosed in New Jersey, but exclude military cases. Data for 1957 to date include New Jersey resident cases only. Primary and Secondary and Early Latent Syphilis numbers for 1944 are not available.

SYPHILIS AND GONORRHEA CASES BY COUNTIES AND MAJOR CITIES

NUMBERS AND RATES PER 100,000 ESTIMATED POPULATION: 1963

AREA	SYPHILIS						GONORRHEA	
	ALL STAGES		PRIMARY AND SECONDARY		EARLY LATENT			
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
STATE TOTAL	5,644	87.3	1,202	18.6	762	11.8	4,424	68.4
ATLANTIC COUNTY	352	207.1	84	49.4	42	24.7	35	20.6
Atlantic City	249	422.0	76	128.8	33	55.9	8	13.6
BERGEN COUNTY	268	31.2	64	7.5	21	2.4	82	9.5
BURLINGTON COUNTY	104	41.1	16	6.3	7	2.8	24	9.5
CAMDEN COUNTY	281	66.6	51	12.1	37	8.8	81	19.2
Camden City	200	173.9	43	37.4	27	23.5	66	57.4
CAPE MAY COUNTY	46	88.5	2	3.8	7	13.5	3	5.8
CUMBERLAND COUNTY	230	203.5	43	38.1	20	17.7	68	60.2
ESSEX COUNTY	1,898	204.3	452	48.7	344	37.0	2,031	218.6
Bloomfield	13	24.5					3	5.7
East Orange	124	161.0	22	28.6	28	36.4	45	58.4
Irvington	34	57.6	4	6.8	1	1.7	3	5.1
Newark	1,556	394.9	406	103.0	292	74.1	1,932	490.4
GLOUCESTER COUNTY	92	61.7	4	2.7	14	9.4	6	4.0
HUDSON COUNTY	498	83.1	75	12.5	51	8.5	290	48.4
Bayonne	32	43.8	8	11.0	3	4.1	15	20.5
Hoboken	32	66.7	2	4.2	4	8.3	6	12.5
Jersey City	333	123.8	55	20.4	34	12.6	255	94.8
Union City	38	74.5	3	5.9	5	9.8	5	9.8
HUNTERDON COUNTY	36	62.1			2	3.4	4	6.9
MERCER COUNTY	360	129.5	72	25.9	46	16.5	405	145.7
Hamilton Township	12	16.4	1	1.4	1	1.4	5	6.8
Trenton	277	251.8	62	56.4	40	36.4	396	360.0
MIDDLESEX COUNTY	177	36.2	28	5.7	10	2.0	111	22.7
Woodbridge Township	13	14.0			1	1.1	5	5.4
MONMOUTH COUNTY	230	62.2	40	10.8	35	9.5	123	33.2
MORRIS COUNTY	67	22.9	4	1.4	10	3.4	22	7.5
OCEAN COUNTY	51	40.8	6	4.8	11	8.8	15	12.0
PASSAIC COUNTY	389	90.7	150	35.0	46	10.7	438	102.1
Clifton	21	23.9	7	8.0	1	1.1	5	5.7
Passaic City	68	128.3	12	22.6	9	17.0	16	30.2
Paterson	281	193.8	129	89.0	35	24.1	404	278.6
SALEM COUNTY	74	119.4	6	9.7	9	14.5	20	32.3
SOMERSET COUNTY	63	40.0	2	1.3			17	10.8
SUSSEX COUNTY	39	72.2	3	5.6	2	3.7	3	5.6
UNION COUNTY	312	57.9	72	13.4	31	5.8	171	31.7
Elizabeth	133	125.5	44	41.5	16	15.1	84	79.2
Union Township	15	26.8	1	1.8			12	21.4
WARREN COUNTY	15	22.7					4	6.1
STATE INSTITUTIONS	27		1		10		10	
Military Personnel	31		25		6		456	
Civilians living on posts	4		2		1		5	

Note: Gonorrhea includes 351 cases reported as having epidemiologic treatment for gonorrhea.
Rates not computed for State Institutions and Military Posts due to lack of population base.

M3622

SYPHILIS AND GONORRHEA CASES BY COUNTIES AND MAJOR CITIES
NUMBERS AND RATES, NEW JERSEY: 1962

	Syphilis							
	All Stages		Primary and Secondary		Early Latent		Gonorrhea(1	
Area	Number	Rate(2)	Number	Rate(2)	Number	Rate(2)	Number	Rate(
New Jersey	6,325	99.7	1,219	19.2	870	13.7	4,085	64.4
Atlantic County	321	192.2	58	34.7	21	12.6	64	38.3
Atlantic City	229	388.1	53	89.8	17	28.8	44	74.6
Bergen County	245	29.3	47	5.6	29	3.5	65	7.8
Burlington County	94	38.5	9	3.7	16	6.6	30	12.3
Camden County	317	76.8	6[illegible]	15.3	45	10.9	63	15.3
Camden City	244	212.2	54	47.0	40	34.8	48	41.7
Cape May County	49	96.1	2	3.9	5	9.8	5	9.8
Cumberland County	257	231.5	25	22.5	32	28.8	52	46.8
Essex County	2,074	223.7	474	51.1	336	36.2	1,743	188.0
Bloomfield	22	42.3	3	5.8	4	7.7		
East Orange	124	161.0	17	22.1	22	28.6	30	39.0
Irvington	26	44.1	3	5.1			1	1.7
Newark	1,750	439.7	433	108.8	287	72.1	1,636	411.1
Gloucester County	95	65.5	11	7.6	12	8.3	42	29.0
Hudson County	758	125.9	76	12.6	73	12.1	298	49.5
Bayonne	55	74,3	6	8.1	3	4.1	15	20.3
Hoboken	49	102.1	13	27.1	9	18.8	8	16.7
Jersey City	536	197.8	44	16.2	51	18.8	264	97.4
Union City	44	86.3	8	15.7	2	3.9	5	9.8
Hunterdon County	29	50.9	2	3.5			1	1.8
Mercer County	365	132.7	70	25.5	57	20.7	333	121.1
Hamilton Twp.	11	15.7	1	1.4	2	2.9	2	2.9
Trenton	292	263.1	64	57.7	47	42.3	319	287.4
Middlesex County	200	42.4	20	4.2	25	5.3	129	27.3
Woodbridge Twp.	19	21.3					2	2.2
Monmouth County	289	80.5	44	12.3	51	14.2	145	40.4

SYPHILIS AND GCNORRHEA CASES BY COUNTIES AND MAJOR CITIES
NUMBERS AND RATES, NEW JERSEY: 1962 (Continued)

Area	Syphilis						Gonorrhea (1)	
	All Stages		Primary and Secondary		Early Latent			
	Number	Rate (2)	Number	Rate (2)	Number	Rate (2)	Number	Rate (2
Morris County	109	38.5	19	6.7	9	3.2	27	9.5
Ocean County	40	33.3	2	1.7	4	3.3	17	14.2
Passaic County	476	112.8	201	47.6	72	17.1	387	91.7
Clifton	20	23.3	3	3.5	1	1.2	6	7.0
Passaic City	81	152.8	18	34.0	10	18.9	22	41.5
Paterson	348	240.0	176	121.4	61	42.1	356	245.5
Salem County	94	154.1	15	24.6	15	24.6	12	19.7
Somerset County	44	28.6	2	1.3	2	1.3	21	13.6
Sussex County	33	62.3	3	5.7	2	3.8	3	5.7
Union County	327	61.9	37	7.0	37	7.0	115	21.8
Elizabeth	105	98.1	16	15.0	15	14.0	57	53.3
Union Twp.	17	30.9	2	3.6	1	1.8	6	10.9
Warren County	34	52.3	6	9.2	6	9.2	3	4.6
State Institutions	41	(3)	5	(3)	15	(3)	2	(3)
Military Posts	34	(3)	28	(3)	6	(3)	528	(3)

(1) Includes 342 cases reported as having epidemiologic treatment for gonorrhea.

(2) Rates per 100,000 estimated population.

(3) Rates not computed due to lack of population base.

Prepared by the Public Health Statistics Program
New Jersey State Department of Health
March 12, 1963

CIVILIAN CASES OF PRIMARY AND SECONDARY SYPHILIS BY AGE
NEW JERSEY: 1958 – 1962

	Years				
Age	1962	1961	1960	1959	1958
State Total	1,195*	864	665	302	170
Under 10	2	3			
10					
11		1			2
12	6				
13	5		1	1	1
14	4	4	1	1	
10-14	15	5	2	2	3
15	17	7	4	1	1
16	19	15	5	6	3
17	36	18	16	5	4
18	42	27	24	14	8
19	48	36	19	12	11
15-19	162	103	68	38	27
20	45	44	30	8	9
21	78	49	48	16	10
22	59	45	45	18	10
23	64	49	45	19	8
24	75	51	36	26	5
20-24	321	238	204	87	42
25	59	46	43	15	11
26	52	36	39	9	9
27	56	41	24	11	7
28	47	39	31	14	8
29	42	46	24	12	4
25-29	256	208	161	61	39
30	38	28	40	16	6
31	31	26	24	7	2
32	40	27	20	13	9
33	26	16	16	8	4
34	31	17	15	5	5
30-34	166	114	115	49	26

CIVILIAN CASES OF PRIMARY AND SECONDARY SYPHILIS BY AGE
NEW JERSEY: 1958 – 1962 (Continued)

Age	Years 1962	1961	1960	1959	1958
35	31	19	14	13	5
36	22	14	10	5	2
37	26	20	11	5	3
38	24	17	9	7	1
39	16	10	2		2
35-39	119	80	46	30	13
40	19	10	7	3	5
41	15	7	10	1	1
42	16	9	7	5	
43	11	8	8	1	1
44	8	14	3	4	
40-44	69	48	35	14	7
45	7		3	3	1
46	7	7	3	1	
47	7	5	1	1	
48	5	5	6	1	2
49	5	6		2	1
45-49	31	23	13	8	4
50 and over	35	30	13	11	7
Age not stated	19	12	8	2	2

*Includes 4 military personnel in which the reporting source was a private physician, clinic, hospital or other institution.

CIVILIAN CASES OF GONORRHEA BY AGE, NEW JERSEY: 1958 – 1962

Age	Years 1962	1961	1960	1959	1958
State Total	3,568	4,302	4,778	4,646	5,493
Under 10	41	33	31	44	44
10	6	1	2	4	7
11	1			1	
12	6	4	6	3	4
13	16	6	9	17	14
14	16	20	27	34	43
10-14	45	31	44	59	68
15	43	32	33	61	66
16	68	62	83	95	129
17	84	107	135	115	183
18	149	157	195	190	253
19	158	204	226	263	320
15-19	502	562	672	724	951
20	159	203	225	282	353
21	357	459	516	424	411
22	306	358	382	336	424
23	231	261	349	321	377
24	195	264	324	263	345
20-24	1,248	1,545	1,796	1,626	1,910
25	229	246	245	261	292
26	166	210	238	229	269
27	152	184	191	202	216
28	149	165	175	187	219
29	126	147	147	156	153
25-29	822	952	996	1,035	1,149
30	120	137	194	143	201
31	75	120	111	108	126
32	77	94	134	96	155
33	73	91	99	72	102
34	70	71	90	68	84
30-34	415	513	628	487	668

CIVILIAN CASES OF GONORRHEA BY AGE, NEW JERSEY: 1958 – 1962 (Continued)

	Years				
Age	1962	1961	1960	1959	1958
35	66	85	93	78	86
36	45	58	67	54	80
37	40	54	52	46	60
38	53	35	54	54	45
39	41	42	36	33	49
35-39	245	274	302	265	320
40	25	42	30	44	49
41	23	19	17	20	18
42	25	29	22	23	29
43	18	17	22	16	24
44	7	15	22	21	21
40-44	98	122	113	124	141
45	10	16	31	15	22
46	8	8	10	14	15
47	13	9	8	14	21
48	6	13	15	11	15
49	6	8	16	14	13
45-49	43	54	80	68	86
50 and over	39	55	51	47	59
Age not stated	70	161	65	167	97

VENEREAL DISEASE CASES (INCLUDING MILITARY) BY AGE GROUPS, NUMBERS AND RATES per 100,000 population: 1963

AGE GROUP	TOTAL		SYPHILIS		GONORRHEA		OTHER VENEREAL DISEASES	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
All Ages	10,087	156.0	5,644	87.3	4,424	68.4	19	0.3
Under 1	18	13.2	14	10.3	4	2.9		
1–4	18	3.3	5	0.9	13	2.4		
5–9	20	3.2	1	0.2	19	3.1		
10–14	52	9.4	17	3.1	35	6.3		
15–19	940	223.8	287	68.3	650	154.8	3	0.7
20–24	2,518	734.1	778	226.8	1,734	505.5	6	1.7
25–44	3,986	217.8	2,199	120.2	1,780	97.3	7	0.4
45–64	1,638	116.3	1,530	108.6	106	7.5	2	0.1
65+	579	96.2	576	95.7	3	0.5		
Unstated	318		237		80		1	

PRACTICES IN THE CONTROL OF VD

A. BRIEF HISTORY:

It must be recognized that immediate control depends upon treatment of the infected and prevention of spread by the infected. Due to the automobile and to the general mobility of our society (35 million families change their homes annually) it is necessary to understand the importance of cooperation between people, agencies, and communities. This calls for close working between state and federal VD programs.

Most helpful in the control of VD is the kind of therapy developed after World War II, and the work of the venereal disease investigator.

Our VD program today concentrates on syphilis. The venereal diseases, chancroid, lymphogranuloma venereum, and granuloma inguinale are not widespread in the United States. Gonorrhea, though very much more prevalent than syphilis, is not as devestating in its total effect as is syphilis. Moreover, gonorrhea is not always easy to diagnose, especially in women, and infection spreads very rapidly. Nevertheless, the disease does have serious consequences.

In 1918 the Chamberlain-Kahn Act was passed. As a result of this act the U. S. Public Health Service established a Division of VD Control. Clinics were established throughout the country. Considerable money was invested in research for diagnosis, prevention, and cure of VD; states were supplied with funds to maintain the clinics.

The federal grant for these clinics was withdrawn by 1926. Dr. Parran, as Surgeon General, in 1936 worked for the reestablishment of a Federal program to control VD. (See Dr. Parran's Shadow on the Land which he used to stimulate people to action).

A conference on venereal disease control was called by him. The results of that conference set the mode for our present work.

The report stated:

First, every early case must be located, reported, its source ascertained, and all contacts followed up to find possible infections. Second, enough money, drugs, and doctors must be secured to make treatment possible in all cases; it is not in the public interest for treatment, which is out most practical means of control, to be retarded or precluded by cost. Third, both public health agencies and private physicians throughout the country must be aligned to form a united front and re-educated to use scientific modern methods in their joint fight against syphilis. In addition, citizens must be informed as to the means and methods required for individual and public protection.

In 1938 Congress passed a bill reestablishing federal aid to states for the prevention, treatment, and control of VD (LaFollette - Bullwinkle Bill).

When Dr. John Mahoney recommended the successful treatment of syphilis with penicillin in 1943 there was an immediate drop in VD. Instead of treatment going on for years, it became a matter of weeks, then of days.

In 1954 a single injection of penicillin (Benzathine penicillin G) cured early syphilis and the end of VD seemed in sight.

Immediately federal funds were withdrawn. By 1957 funds for services at all levels were cut back. It appears that a direct correlation exists between the prevalence of the disease and the amount of money spent to control it. (See reprint in Appendix from New York Times "Syphilis Cases Rise")

B. THE CURRENT PRACTICES USED IN THE CONTROL OF VD ARE:

1. Medical Treatment

This consists of administering penicillin injections for both syphilis and gonorrhea unless the patient is sensitive to penicillin, in which case other antibiotics are used.

2. Case-Finding

Case-finding is a continuous process. A venereal disease can be wiped out without a vaccine only if every infectious case is located and reported, its source verified, all reported contacts followed up in order to find all who are infected. All infected people must be cured wherever they are and as soon as possible. This means at once.

a. Some cases are found when people voluntarily come to the clinic to be examined. Doctors immediately report VD cases to the health department.

b. Where there are groups which are suspected of having a high rate of infection large numbers are given blood tests. This is known as a selective mass blood testing. Many cases are found during such testing.

c. Cases are discovered during routine premarital and prenatal blood testing.

d. Some cases are discovered among people who are engaged in selected occupations like food handling where blood tests are required.

3. Contact interviewing and investigation

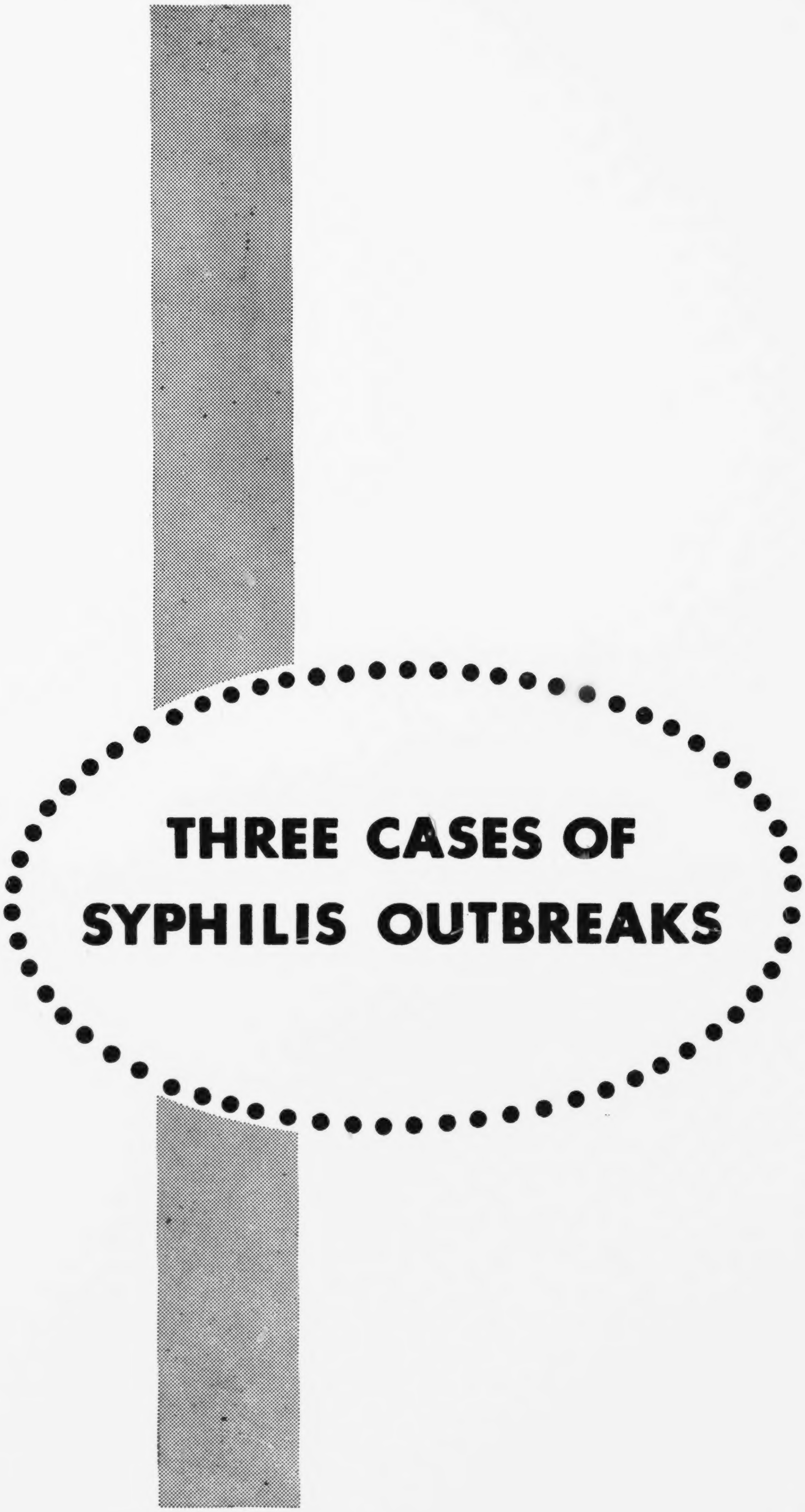
VD investigators are specially trained for their jobs. As soon as a case of VD is reported an investigator interviews the person and urges him to reveal the names of his contacts. If the case is in its primary stage the patient is asked to recall all his sex contacts for a period of the duration of his symptoms plus three months; if the patient has secondary symptoms he is asked to recall his contacts from the period of his symptoms plus six months.

The investigator tries to find the contacts and urges them to come for a medical examination and for treatment if necessary. Each contact in turn is asked to reveal his contacts. A search must be continuous until the outbreak is traced back to its source.

All information is strictly confidential. It is so required by law.

4. Public Education -

This should be introduced at each level in school and through all available media. Already there have been VD programs on TV, on radio, in newspapers and in magazines. (See reprints in Appendix) Parent groups at PTA meetings should be informed of the nature and seriousness of VD. "The eradication of venereal disease is possible, but it certainly will not come unless we redouble our efforts medically, morally and educationally in an all-out attack on this major public health problem." (Howard A. Rusk, M.D. "Syphilis Cases Rise" New York Times, May 6, 1962.)



THREE CASES OF SYPHILIS OUTBREAKS

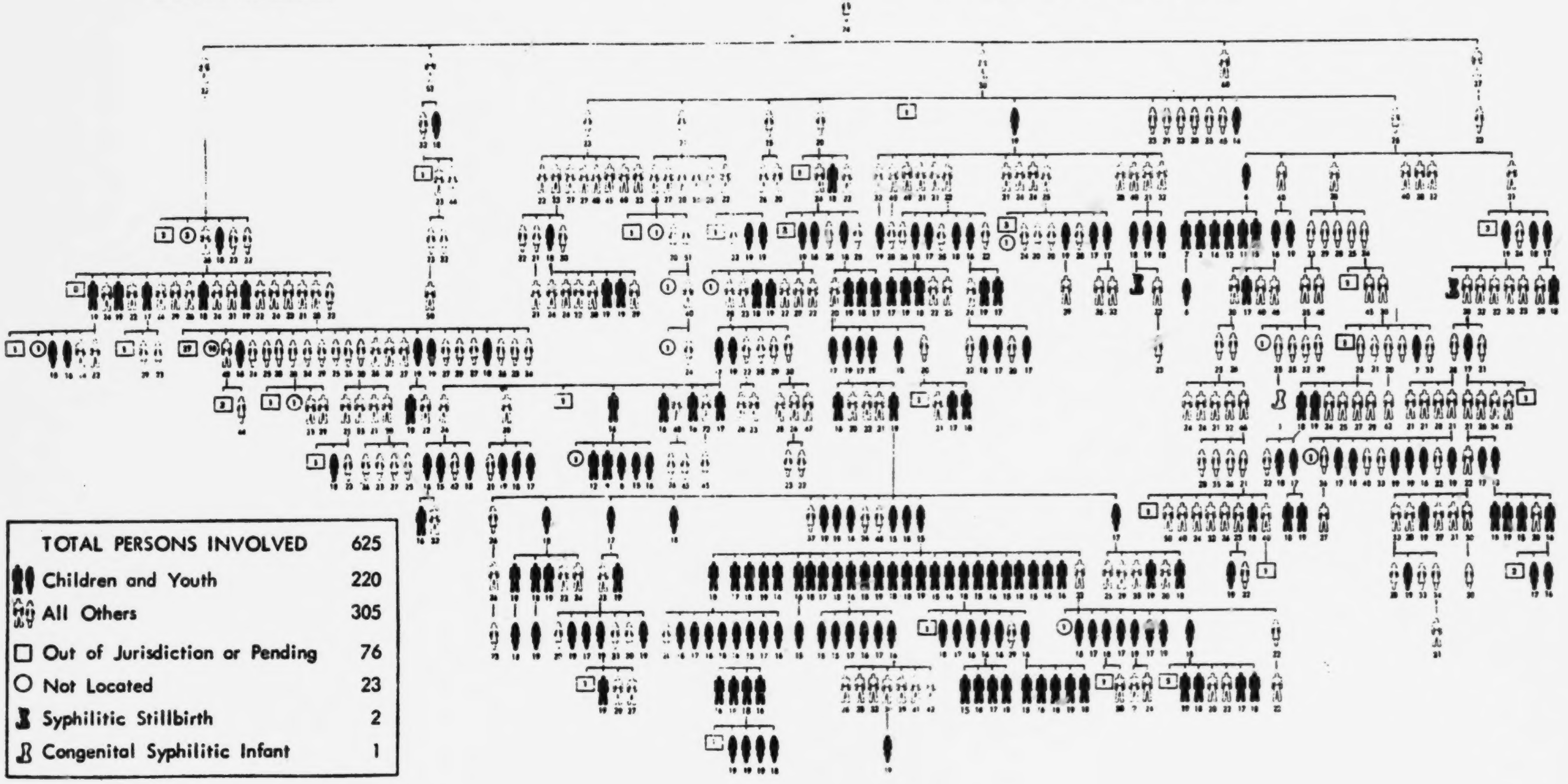
66/67

Case I

CHILDREN AND YOUTH INVOLVED IN A TYPICAL SYPHILIS EPIDEMIC - 1958

NUMBERS BENEATH CHARACTERS INDICATE AGES OF PERSONS INVOLVED. THOSE UNDER AGE 20 ARE SHOWN IN BLACK.

ORIGINAL CASE WAS TREATED AND REPORTED BY A PRIVATE PHYSICIAN. EPIDEMIOLOGY WAS CARRIED ON BY PUBLIC HEALTH PERSONNEL.


TOTAL PERSONS INVOLVED 625
Children and Youth 220
All Others 305
☐ Out of Jurisdiction or Pending 76
○ Not Located 23
Syphilitic Stillbirth 2
Congenital Syphilitic Infant 1

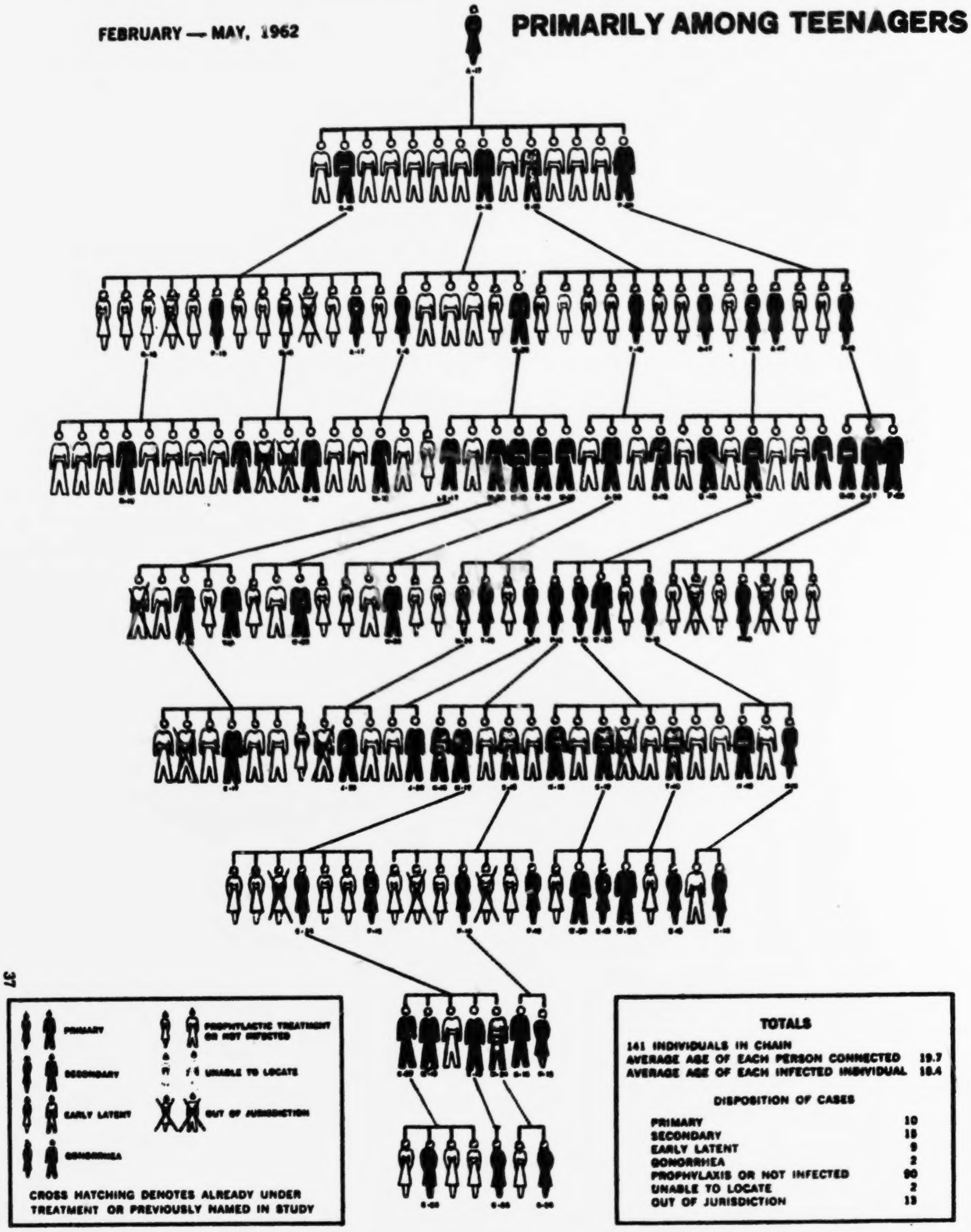
From: "VENEREAL DISEASE IN CHILDREN AND YOUTH", U.S. Department of Health, Education, and Welfare, Public Health Service.

M3376

INFECTIOUS SYPHILIS: OUTBREAK IN AN ALABAMA CITY

FEBRUARY — MAY, 1962

PRIMARILY AMONG TEENAGERS


37
PRIMARY
SECONDARY
EARLY LATENT
GONORRHEA
PROPHYLACTIC TREATMENT OR NOT INFECTED
UNABLE TO LOCATE
OUT OF JURISDICTION
CROSS HATCHING DENOTES ALREADY UNDER TREATMENT OR PREVIOUSLY NAMED IN STUDY

TOTALS

141 INDIVIDUALS IN CHAIN	
AVERAGE AGE OF EACH PERSON CONNECTED	19.7
AVERAGE AGE OF EACH INFECTED INDIVIDUAL	18.4

DISPOSITION OF CASES

PRIMARY	10
SECONDARY	15
EARLY LATENT	9
GONORRHEA	2
PROPHYLAXIS OR NOT INFECTED	90
UNABLE TO LOCATE	2
OUT OF JURISDICTION	13

Thirty-four cases of syphilis and two of gonorrhea were found and treated in this chain of infectious VD which involved a total of 141 persons. Five of the infected persons brought to treatment attended elementary school. Their ages were 6, 10, 12, 13 and 15. Twelve more infected individuals attended high school. The youngest person brought to treatment was a child 6 years of age infected with secondary syphilis. The average age of each person brought to treatment was 18.4.

From: TODAY'S VD CONTROL

Problem, The Association of State and Territorial Health Officers, The American Venereal Disease Association, The American Health Association, Tenth Annual Joint Statement, March, 1963.

CASE III

Dr. Nicholas Fiumara, Director of VD Control for the State of Massachusetts, made a study of a rather limited epidemic involving both syphilis and gonorrhea in a Massachusetts town of 48,000.

Although only 47 persons were involved, (recent epidemics have involved as many as 600 persons) this study can be very helpful in explaining many things about epidemics to persons not familiar with venereal disease problems. Following are some of the more interesting features.

The first link in the sex chain was discovered by an alert private physician who took a blood test on a patient, diagnosed syphilis, then called on the health department for assistance.

The 47 persons, all of the white race, ranged in age from 13-1/2 to 39. Five were younger than 18.

The patient group contrasted in several ways with the rest of its community.

DESCRIPTION OF THE COMMUNITY:

Majority in semi-skilled occupation. Most own homes or rent in good or fairly good residential areas. There are no real slums in the area. Most families have regular church affiliations.

DESCRIPTION OF THE PATIENT GROUP:

Most represented the upper ranks of the lowest socio-economic group. Thirty-five had completed grade school, but only seven of these had completed high school. Of those who worked, all were semi-skilled or unskilled, factory workers predominating. Almost all came from homes broken by divorce, separation, desertion, or other maladjustment. Their recreational activities centered around the bar - in fact, one particular bar figured importantly. No moral code was evident among the group. Sex behavior was not considered as right or wrong. Almost none were church members; and the few who were did not attend.

FOLLOWING ARE DESCRIPTIONS OF SOME OF THE PERSONS INVOLVED:

Alice, an attractive girl of 19, was the first patient. Married two years, she worked in a shoe factory to support herself and her 2 year old son. Husband, Boris, seldom worked and never held a job long. He was a heavy drinker, got drunk frequently and beat her. They had been separated temporarily several times.

Boris was a good looking boy of 28. He beat Alice when he found out she had been to see the doctor. He did not doubt her fidelity. He admitted he had penile sores two months before, but didn't bother to do anything about them. He named seven contacts.

One of Boris contacts was Betty, a very attractive girl of 16. She was single. Worked infrequestly. Frequented bars. Her mother and father were separated. Mother was an alcoholic. Betty continued sexual relations with Boris even after she was diagnosed; and she finally became pregnant out of wedlock.

Betty had a sister, Helen, also a contact to Boris. Helen was 14. She had had trouble with the police and was a habitual truant.

Another of Boris' contacts was Dorothy, 28, a very neat, conservative looking type. She was divorced and remarried.

Dorothy introduced her cousin, Charlotte, 20, to Boris, and Charlotte also had sexual relations with Boris. Charlotte was married and passed syphilis on to her husband.

One of the bartenders at a bar frequented by this group was Donald. He was exposed to both Dorothy and Charlotte. He developed syphilis and named six contacts. He was married but his wife was not infected.

Dorothy sometimes worked as a barmaid. She introduced her cousin, Charlotte, to Edward, a patron who lived out of State but worked in this community. Thus, Edward became and out-of-state contact.

Boris also named Ellen, age 18. She was single, but had an 8 month old illegitimate daughter. Ellen's mother was dead; her father lived out of State, and she lived with a married sister. She was known as a problem child.

Eighteen year old Ellen passed syphilis on to 28 year old George.

Still another of Boris' contacts was 19 year old Gilda. She had been separated from her husband. She had met Boris through a friend, Jack, 22. She passed syphilis on to Jack also.

One of 14 year old Helen's contacts was Neal, 29. They met at a bar and drove to the city dump where they had intercourse.

Another of Helen's contacts was Oscar, 30, who separated from his wife because he said she was frigid. He got syphilis and gonorrhea from Helen presumably, and passed the gonorrhea on to his girl friend, Janet, 21.

Oscar also included among his contacts, Marian, 13, an eighth grade student with a reputation for habitual truancy. She developed syphilis.

Still another of Boris' contacts was Irma, 39, an attractive widow with 9 children, three illegitimate. Irma was on general relief. She was visited by men at all hours of the day and night and nobody was turned away. Yet, she did not take money.

Irma had a son-in-law, Quentin, 23, with whom she also had intercourse. Her daughter, Lorraine, 17, got syphilis from Quentin while pregnant. When Lorraine found out about her mother and her husband, she said: "Ican't say I like it. But you can't blame him too much. That's natural."

SOME SCIENTIFIC CONTRIBUTIONS

In the 1500's syphilis was recorded in Europe. It spread to Africa and Asia, killing and crippling millions. All kinds of cures were tried. Some worked; most were useless. Mercury in various forms gave the best cure.

In 1909 Ehrlich announced the first specific cure. It was called salvarsan, and also known as 606.

Germany retained a monopoly on the manufacture of the drug until the patent rights were disclaimed and the U.S. began to manufacture salvarsan, calling it arsphenamine.

Some of the scientists and their work which contributes to the control of syphilis follow:

1879 - Albert Neisser (1855-1916) discovered the organism of gonorrhea, Neisseria gonorrhea.

1903 - Elie Metchnikoff (1845-1916) and Pierre Roux (1853-1933) infected animals (the first was an ape) with syphilis and studied the disease. By cutting off an ape's ear after they had applied syphilis germs to a scratch on that ear, they discovered, by observing that the animal showed no signs of the disease, that the germ lingers for some time at the point of introduction into the body. Metchnikoff developed an ointment, calomel, which was successful in curing syphilis when applied to such a point.

1906 - Fritz Schaudinn (1871-1906) and Paul Erich Hoffman discovered the microbe which causes syphilis. It is pale and corkscrew-shaped. Schaudinn speculated that it was a member of the animal kingdom and related to the trypanosomes.

1906 - August von Wasserman (1866-1925), Albert Neisser (1855-1916) and Bruck developed a test of blood serum and spinal fluid for active syphilis. This test was based upon the body reaction to foreign organic bodies. Compounds are formed to destroy foreign bodies with the help of a blood component called complement. In the formation of these anti-bodies this complement is disintegrated. In the Wasserman test, if the complement disappears, the blood contains syphilis germs.

1909 - Paul Ehrlich (1854-1915) discovered an arsenic compound, arsphenamine which is lethal to a certain type of germ (trypanosomes) and harmless to humans. When Schaudinn (see above) reported the discovery of the germ which causes syphilis he spoke of a similarity between that germ and the type of germ with which Ehrlich was working. Ehrlich tried his arsphenamine on the syphilis germ with great success. This was the first specific treatment for syphilis.

1929 - Alexander Fleming (1881-1955) discovered the anti-bacterial powers of the mold from which the liquid substance, penicillin, is derived. While performing some research he noticed a bacteria-free ring on a culture plate where this mold had developed.

1937 - Thomas Parran (1892-) while Surgeon General of the United States Public Health Service (in 1937) published Shadow on the Land, the first book which acquainted the public with the dangers of venereal disease. He tried to break down any possible barriers to the eradication of the disease.

1943 - John F. Mahoney (1889-1957) first utilized Fleming's discovery of penicillin's germ-killing power in a treatment far safer and faster than the current refine- of Ehrlich's arsenic compound. The period of treatment was reduced from 72 to 2 weeks. Since then, many other refinements have been made on the penicillin cure.

SOME REFERENCES TO VD IN WESTERN LITERATURE

1. Girolamo Fracastro, Fracastro: Syphilis; Or The French Disease, transl. Heneage Wynne-Finch (London: William Heinemann Medical Books Ltd., 1935).

Fracastro (1478 - 1553) of Verona invented the term syphilis in his long Latin Poem, which was occasioned by an outbreak in 15th century Europe of a strange malady (syphilis). The poem received considerable attention because Europe was terrified with the suspicion that this new disease might be similar to the Black Plague. Fracastro describes symptoms of syphilis, and suggests cures, which are derivative of the teachings of Galen, whose authority was great in the 16th century, and even beyond. Students of the history of science will find amusing and absorbing recommendations for the treatment of VD made with an eye for the actions of drugs and diets dependent upon the "humors;" for the qualities of heat, moisture, dryness and cold. And students can learn from this poem the huge amount of myth which surrounds the basic facts of VD; they can learn how they must be informed, and how they must inform others. One reading by the teacher should prove the point, i.e., the description on p. 159 of the origin of the disease: how it was first contracted by the shepherd Syphilus, who provoked the anger of Apollo.

2. The Autobiography of Benevenuto Cellini, transl. Robert H. Cust (New York: Dodd, Mead & Company, 1961), pp. 137, 139, 140.

"During the time that the Pope stayed in Bologna I had developed an inflammation in my eyes with so much pain that for anguish I could scarcely live, so that this was the principal reason that I had not progressed with the work; and so severe was the ailment that I thought I should most certainly become blind. (A doctor advised him to) '. . . take some corn-flowers with their stems, flowers and roots all together, then proceed to distill them over a slow fire, and with that liquid bathe your eyes several time a day, and you will most certainly be cured of this ailment; . . . but it seemed that I was covered with certain small red blisters, as large as farthings. (After about 100 days). . . I was thoroughly cured, and thenceforward with the greatest diligence I gave my attention to securing my health for the future."

The easy style and sense of humor of the 16th century Italian sculptor make him accessible for secondary as well as college readers. Cellini, for many, is a summary of the Renaissance spirit, and his reference here to the Roman doctors' treatment for syphilis is an interesting comment on Renaissance medicine; but more important for the teacher, the reference to treatment provides a perfect analogue which can be easily used to demonstrate to students the necessity for fast, correct treatment. Cellini's concluding note is an obvious reference to prophylaxis, and again serves as warning for us today. We might wonder, in light of the travails Cellini describes, what great art the Renaissance might have lost had he not recovered - and what great art *was* lost, forever.

3. a) Ben Jonson, *The Alchemist* (II. iii. 305-7)

I'll have gold before you,
And with less danger of the quicksilver,
Or the hot sulphur.

The reference here is to the usual Elizabethan treatment for VD.

b) Christopher Marlowe, *Doctor Faustus* (I. iv.)

Clown. Gridirons! What be they?
Wagner. Why, French Crowns.
Clown. Mass, but in the name of French crown, a man were as good have as many English counters. And what should I do with these? (*counter*: "debased coin;. . . typically a thing of no intrinsic value." (Onions)).
Wagner. Why, now sirrah, thou art at an hour's warning, whensoever and wheresoever the Devil shall fetch thee.
Clown. No, no. Here, take your gridirons again.
Wagner, Truly, I'll none of them.
Clown. Bear witness I gave them him.
Clown. Bear witness I gave them you again.

French crown: "with pun on the sense 'top of the head' and with reference to the baldness produced by 'The French disease.'" (Onions.) We find the pun employed by Shakespeare in: *Measure For Measure* I. 11. 55; *Midsummer Night's Dream* I. ii. 100; *All's Well That Ends Well* II. ii. 24. This usage is not so familiar in Elizabethan and Jacobean drama as the familiar "pox" (a pox on him, etc.) which refers to the facial symptoms of syphilis, but which refers as well to smallpox and ravages of the plagues that were beleaguering Europe ; and such was the plague of 1610, the year in which Jonson's *Alchemist* was first played. These references are not thematic, but topical and metaphorical devices; as such they illustrate for the student the importance of VD in common Renaissance life. And they show as well a willingness to deal with the existence of VD - a willingness largely absent in literature from the end of the 17th century through the first quarter of the 20th.

c) Sir John Suckling, "A Session of the Poets" (Works, A. H. Thompson, 1910).

Will Davenant asham'd of a foolish mischance
That he had got lately travelling in France,
Modestly hoped the handsomnesse of's Muse
Might any deformity about him excuse!

Sir William Davenant, a 17th century English poet and friend of wits in the court of Charles I, was tirelessly rallied by his fellow poets about his nose, deformed by syphilis and mercury treatments. In its relation to the prevalence of VD in royal courts, the reference is interesting. But it hardly serves a more instructive purpose.

4. Voltaire, Candide.

"My dear Candide: You remember Paquette, the maid-servant of our august Baroness; in her arms I enjoyed the delights of Paradise which have produced the tortures of Hell by which you see I am devoured; she was infected and perhaps is dead. Paquette received this present from a most learned monk, who had it from the source; for he received it from an old countess, who had it from a cavalry captain, who owed it to a marchioness, who derived it from a page, who had received it from a Jesuit, who, when a novice, had it in a direct line from one of the companions of Christopher Columbus. For my part, I shall not give it to anyone for I am dying."

The 18th century satiric masterpiece uses venereal disease as one of many illustrations of a world in which far from all is well. The reference to VD in the concluding pages of Chap. IV certainly shows the danger of "Chain-reaction" communication. The book is recommended for mature high school students, and on; that is, those who can realize the satiric intention of such lines as, "In this cure (for syphilis) Pangloss only lost one eye and one ear."

5. The romantic German philosopher, Friedrich Nietzsche, began to write strange letters in 1889, signing them "Caesar," "The King of Naples," "the crucified one," and signifying complete mental collapse. He was insane until his death 10 years later. Colin Wilson (The Outsider. London: Victor Gollancz Ltd., 1956) states (p. 130): "Modern research supports the view that his collapse was brought on by venereal disease contracted in his student days from a prostitute" Thomas Mann's Doctor Faustus is a fictionalized version of Nietzche's life, and would provide in its treatment of this episode a brilliant rendering of the mental effects of VD.

6. Henrik Ibsen, Ghosts.

Os[illegible] At last he said: "You have had the canker of disease in you practically

from your birth" - the actual word he used was "vermolu."
Mrs. Alv. (anxiously) What did he mean by that?
Osw. I couldn't understand him, either - and I asked him for a clearer explanation. And then the old cynic said (clenching his fist) oh! -
Mrs. Alv. What did he say?
Osw. He said: "The sins of the fathers are visited on the children."

For high school juniors, on. This play examines, in part, the effects of VD transmitted from an untreated father to an unborn child. Because it is a moving psychological dilemma in which believable lives are shattered and destroyed, this treatment of irresponsible promiscuity and its effects on the innocent is far more effective than Brieux's Damaged Goods. The higher the literary maturity of the student, the greater the number of psychological, social ramifications to be discussed here: this play can lead an older class to a thoughtful and still highly emotional consideration of VD. Although VD is a plot-device, and not the theme, its presentation is so effectively rendered that it is strongly recommended as the first reading of any series for an older group.

7. Louis-Ferdinand Celine, Death On the Installment Plan, transl. John H. P. Marks (New York: Little, Brown & Company, 1938).

This intense and naturalistic novel was written by a doctor, and the sections here quoted reveal a physician's knowledge of the atmosphere of VD clinics and their patients. The teacher can use such passages for an intellectualized "shock technique," if he is working with more mature students, who are capable of realizing that such writing is not sensationalism, but an effort to depict and comment on the social effects of a dangerous disease.

(P. 19) "Our practice at the v. d. clinic consisted of strokes which we jotted down right and left on a sheet of foblscap. That's all there was to it. Red stroke: novas. Green: mercury. Allez-oop! The rest of the treatment ran itself. All we had to do after that was to jab the juice into their buttocks or the bend of an arm. The whole thing slid along on rails. Green - arm forward! Yellow - trousers down! Red - both cheeks. Triple dose. Bismuth - hup! Blue - rotting to bits! Up with your pants; swab that arm! A regular rhythm, never a hitch; hundreds and hundreds of them, in endless Indian file, a marathon dance, an unfailing quarry. Swellings, chancres, discharges, disasters - oozing, dripping, pustulating, gaping - the queen disease of the world. . . on her nasty private throne! . . . never unwilling to start it all over again; hiding it from the wife; promising to be more careful in future; doublecrossing us and yelping for joy . . . Uretheras full of needles and mouths full of lies."

8. Damaged Goods, a three-act play by Eugene Brieux. New York: Printed by Brentano's for The Connecticut Society of Social Hygiene, 1912.

The play is a work of propaganda, concerning the effects of VD on a marriage and family. It deals directly, and with Victorian "good taste," with the dangers of the untreated father to his children (unborn), wife, and others. The play was written to inform, and to criticize common misinformed attitudes towards VD. It can be read with comprehension by freshmen in high school, on. The novelized version (Upton Sinclair, Damaged Goods. Philadelphia: John C. Winston Company, 1913) add nothing to the play, but is no less useful in presenting Brieux's ideas about how through lack of treatment we create other victims, and how these in turn create others - and how we so create our modern pathological vicious cycle of venereal disease.

VD AND HISTORY

It is believed that syphilis existed in the Old World before Columbus' voyage to America. Certainly after his return to Spain in 1493 it began to attract great attention. There was a fierce outbreak of it between February and May of 1495. By June it had reached France, Switzerland and Germany. In 1497 it was in England, Scotland and Greece. In 1498 Vasco da Gama carried it to India. In 1505 it was in China.

In 1494 Charles VIII of France enlisted an army to conquer Naples, which it did. In the Chroniques of Jean Molinet we are told how Charles, after his return from battle, was afflicted with "la maladie de Naples" ("the malady of Naples:" syphilis). But if the disease existed in Naples, as it probably did, its vicious strength was increased with the help of Charles's own troops, many of whom were mercenaries from Spain infected with what Columbus' crews had brought back the year before. What decisions affecting the geography and politics of Europe were made by a man in the grips of syphilis, a disease which in its last stages causes insanity? Out of the long cycle, finally, from Columbus' men to local wives and prostitutes, to Charles's men, to Neopolitan women, to Charles himself, to his unborn children, syphilis emerged as a brutally triumphant fact of history: Charles was the last of the Valois dynasty to rule France because all his heirs to the throne were born dead - of syphilis. His successor was Francis, a malignant king. History was changed, and VD did the changing.

Syphilis again ruled when Louis XIV of France went to his death, the syphilitic ulceration on his leg diagnosed by his doctors as gout. And it was no gout that had a hand, perhaps, in the English Reformation. Tied up with Henry VIII's desire for formation of an Anglican Church was his desire for a male heir to the English throne: his first wife had borne him four dead sons - dead from syphilis. Since divorce was impossible in a Catholic England, part of Henry's wish for separation from Rome lay in his necessity for an heir, a necessity caused by VD. His Anglican wife bore him the daughter who was to rule as Queen of England. Elizabeth, Shakespeare's queen, was her name. But his first wife had borne him a daughter named Mary, a Catholic born before the English Reformation. She succeeded Henry and, to support her legitimacy, tried to force Catholicism back upon England through a most persuasive device: murder. She was called "Bloody Mary," and hundreds of corpses attested to the title. Elizabeth, Henry's daughter born of the Anglican marriage, succeeded Mary, and to support her legitimacy wooed many recently converted followers of Mary back to Anglicanism through the familiar political persuader: execution. Who really ruled, through this turmoil of land reform, religious change, birth, death and desperation? Venereal disease: that other, forgotten factor of history.

If we study it properly, history will not let us forget venereal disease. Reading casually through the account of Captain Cook's fascinating voyage to the

Sandwich Islands we suddenly come upon a passage in which David Samwell, surgeon of Cook's ship, the Discovery, writes in 1786 to defend the expedition from charges of having introduced syphilis to natives of the Islands. Was it there already? Did Cook's men bring the disease home to infect more innocent people who might, under its terrible influence, affect history?

An who is aware of the ravages caused at home by infected British troops returning with VD from India? One wonders how many students are aware of how the staid House of Commons, from about 1865, was rocked for years by thunderous controversy caused by VD. So many British servicemen were being struck down by venereal diseases, the Contagious Diseases Acts were passed, providing in part for registration of prostitutes, and inspection of them for VD. We might find it staggering to realize that the number of new cases of VD in the U. S. Army after World War I exceeded by 100, 000 that war's battle casualties. And we might pause to reflect at how much impetus was given the American Suffragettes, those influential emancipated women of American politics, by their concern for the effects of innocent women of men infected with VD.

Venereal disease has in all probability been with us from the starting-points of history. But it is too largely ingored. A little careful examination will reveal that its deadly influence is present throughout the records of man's various experiences, and that great decisions and terrible events may well have been shaped, wholly or in part, as a result.

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A GLOSSARY OF TERMS

ALOPECIA - Spotty, irregular, temporary baldness which may occur in the secondary stage of syphilis.

BACILLUS - A micro-organism shaped like a rod.

CERVIX - The constricted lower portion (neck) of the uterus extending into the vagina.

CHANCRE - (Pronounced "shanker".) A painless sore which develops at point where spirochete enters body - usually on or around sex organs.

COCCUS - A micro-organism shaped like a sphere.

CONGENITAL SYPHILIS - A form of syphilis contracted by a child from its mother before birth.

CONTAGIOUS - Capable of being transmitted by contact from one individual to another.

DEGENERATION - Deterioration of healthy tissue or organ.

EPIDEMIOLOGY - Medical science treating of epidemics - the step-by-step uncovering or tracing of the causes of an epidemic.

FALLOPIAN TUBE - The long slender tube on each side of the lateral two corners of the uterus which extends to the area of the ovary on the same side.

GONOCOCCUS - The organism causing gonorrhea.

GONORRHEA - Also called clap; a dose; gleet; morning drip; strain. An infectious inflammatory disease usually confined to the genital and urinary tract.

INCUBATION PERIOD - A period of time it takes from infection to the appearance of visible symptoms of the disease.

INFECTIOUS - Germ bearing

LABIA MAJORA - The two folds of skin forming part of the female external organs.

LABIA MINORA - The two folds of mucous membrane at the inner surfaces of the labia majora.

LATENT - Not visible or apparent, dormant.

LESION - Diseased or injured region (tissue).

LOCOMOTOR ATAXIA - A disorder of the nervous system caused by syphilis and characterized by difficulty in co-ordinating voluntary movements of the arms and legs.

NEUROSYPHILIS - A stage of syphilis characterized by involvement of brain and spinal cord which may result in paresis and locomotor ataxia.

PARESIS - Syphilitic infection of the brain causing insanity.

PENICILLIN - A drug developed from a mold and used successfully in the treatment of venereal diseases and several other diseases.

PENIS - The male external genital organ containing the urethra, through which urine and seminal fluid are carried.

PLACENTA - The organ on the wall of the uterus to which the embryo is attached by means of the umbilical cord. Oxygen and nutrients from the mother are supplied to the baby through the placental circulation.

REAGIN - An antibody in the blood manufactured by the body when syphilis germs invade it.

SCROTUM - The pouch containing the testicles, and the tubules connecting the testicles with the prostate gland and urethral canal.

STERILITY - The inability to conceive children because sperms are not produced by the male, or the female cannot bear children.

SPIROCHETE - A micro-organism shaped like a corkscrew.

STS - Serological (blood) test for syphilis.

SYPHILIS - Also called siff; pox; lues; bad blood. A very infectious disease spread by sexual contact.

TREPONEMA PALLIDUM - The specific spirochete organism causing syphilis.

VAGINA - The canal in the female surrounding the cervix and extending to the vulva.

VENEREAL OR VD - A disease transmitted through sexual intercourse.

VULVA - The external portion of the organs of generation in the female.

FILMS ON VENEREAL DISEASE

1. THE INVADER

Motion picture, 16mm., black and white, sound, 43 minutes. Presents information concerning the history, identification, treatment and eventual medical control of syphilis as it has developed over four centuries. Produced at a time when syphilis control was more successful than at present.

2. THE INNOCENT PARTY

Motion picture, 16mm., color, sound, 17 minutes, 1959. A terse, dramatic story of how a young man in a moment of indiscretion contracts VD from a "pick up". He comes to learn the tragic significance of his ill-advised actions and to realize his responsibility to himself and to those he loves. A simple, sincere presentation of the nature, recognition, cure and control of syphilis.

3. DANCE LITTLE CHILDREN

Motion picture, 16mm., color, sound, 25 minutes, 1962. Centering on a syphilis outbreak among teenagers in a typical American city, this thought-provoking film illustrates the responsibility of parents in the prevention of VD

4. A RESPECTABLE NEIGHBORHOOD

Motion picture, 16mm., black & white, sound, 25 minutes, 1961. Depicts the contributions of a health department in the control of syphilis and points out that the disease is not restricted to any particular class of people. Emphasizes harm that can come to young people as a result of ignorance of VD and shows possible effect of a poor family life.

DANCE LITTLE CHILDREN and A RESPECTABLE NEIGHBORHOOD are available on loan basis from VD Control Program, 211 E. State St., Trenton. Please write. It is desirable that these films be delivered and shown by Department representatives who can also be available to speak or answer questions.

THE INNOCENT PARTY and THE INVADER, already viewed by thousands of New Jersey students, parents, teachers and health workers, are still available and are highly recommended. Loan requests may be addressed either to the VD Control Program or the Department of Education Film Bureau in the State House Annex.

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